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LIFE SATISFACTION, LIVING ENVIRONMENT, SOCIO-ECONOMIC SUPPORT AND HEALTH STATUS OF ELDERLY PEOPLE IN OLD AGE HOMES

- A SOCIOLOGICAL STUDY IN TAMILNADU

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FINAL REPORT

POST DOCTORAL FELLOWSHIP FOR WOMEN 2015 - 2017

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DECLARATION

I hereby declare that this research work entitled, **'LIFE SATISFACTION, LIVING ENVIRONMENT, SOCIO-ECONOMIC SUPPORT AND HEALTH STATUS OF ELDERLY PEOPLE IN OLD AGE HOMES - A SOCIOLOGICAL STUDY IN TAMILNADU'** is the result of investigation for the award of Post Doctoral Research work in Sociology. The entire research work was carried out by me in the Department of Sociology, University of Madras, Chennai, Tamilnadu.

I further submit that this research work has not been previously submitted in part or in full by me for any degree or diploma to any University or Institution.

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Chennai -05 **Dr. M. SUGANYA**

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5	Human Rights in Changing scenario of India : An Overview	SHANLAX International Journal of Economics	6-1, 88-93 & Dec2017	ISSN: 2319-961X	1
6	Differential in Living Standard of Inmates in Old age homes of Chennai (Tamilnadu)	Indian Journal of Gerontology	32-1, 21-35 & 2018	ISSN : 0971-4189	1
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9	Virtual Technologies in improving Library Services : An Overview	Asian Journal of Multidimensional Research	7-12, 101-109 & Dec 2018	ISSN : 2278-4853	1
10	Elder Abuse In Urban Context: With Special reference to Metropolitan Cities in India	Elder Abuse and Social Exclusion	53-61 & Jan2019	ISBN : 9789387587724	1
11	Mounting E-Waste in India : An Emerging Threat to Human Health and Environment of Urban Area	Health, Environment and Society	181-193& Feb2019	ISBN : 9789388316231	1
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15	Marginalized and institutionalizing elderly women: Issues and concerns	International Journal of Trend in Scientific Research and Development (IJTSRD)	265-268 4-6 & Sep-Oct 2020	E ISSN: 2456-6470	1

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CHAPTER I

Introduction

1.1 Introduction

The population ageing started in the last century with developed countries, is now encompassing developing countries too. India, by no means, is an exception to this phenomenon. Over the years, the structure of the population has changed and will further change in the time to come. Population ageing has profound social, economic and political implications for a country. The increasing number of older persons put a strain on health care and social care systems in the country. Old age comes with a lot of ailments and diseases. In case of a large number of elderly persons in the population, the country needs more and more health and medical services, facilities and resources, more and more number of hospitals, doctors, nurses is required. Government spending on health care is increased with the increase in the average age of the population.

The phenomenon of population ageing is becoming a major concern for the policymakers all over the world, both for the developed and the developing countries. Our country too is not immune to this demographic change. The changing demographic profile has thrown many new challenges in the social, economical and political domains. The rapid socio-economic transformation has affected various aspects of society. Industrialization, urbanization and migration of population have brought the concept of the nuclear family, as a result of which a section of the family, primarily the elders, are confronting the problems of financial and physical support. There is an emerging need to pay greater attention to ageing-related issues and to promote holistic policies and programs for dealing with an ageing society.

The scenario changed slowly and steadily with the decline or disappearance of the joint family system, which was replaced by the nuclear family system. A 50-year analysis would reveal the great transformation. Many reasons may be attributed for this change, which reflected not only the whole family set-up but also the life pattern of elders, who became dependent, partially or totally. The major factor was the disintegration of families, necessitated by the migration of sons, daughters, also relatives from their places of birth to towns and cities in search of greener pastures. This

was for education, jobs, career enhancement, marriage, amenities and for improved lifestyles. While the younger generation had no difficulty in moving out of the house and adjusting themselves to new environs and the elderly population found the change to be a hardship. For them, to move away from their places with attached sentiments, comforts and property holdings, and fairly happy life, to new environs in the cities were tough. But they had to sacrifice and compromise for the sake of their children and their own needs. So, the stage was set for a new life pattern of life for elders.

There are five patterns that elders today face generally, which are situation-dependent. a) In one situation, elders stay with children in the same house in the city, which ensures financial and health security.

b) In another situation, they live alone in a separate house with children living elsewhere in the city, considering the proximity to places of work or to the educational needs of their children. Here, the family members visit the parents once a week or when any health problems necessitate their presence.

c) In a third scenario, elders stay alone in a town or city while the children live in faraway cities for employment; the children visit once in a few months for occasions or emergencies of health.

d) In a fourth pattern, elders live all alone in the city or old age homes, the children have migrated to foreign countries for higher education, jobs and so on. The children will be living a settled and comfortable life with their family and children, with all material comforts. They will visit the elders once in two or three years; this situation causes health-related and emotional insecurities, though the elders will be financially sound thanks to foreign remittances.

e) In another pattern, elders live with relatives or in old age homes, either with a spouse or alone, with financial, health and emotional insecurity. Elders, both men and women, who remained single without marriage invariably landed in old age homes (OAHs). Each of these situations has its own merits and demerits. While many elders accept the change, others are unable to adjust, and start grumbling and sulking, which is understandable considering the age and exposure to circumstances.

1.2 Background of the study

The problem of ageing is a global problem. It is experienced by all societies. However, the magnitude of ageing and its manifestation are not the same

everywhere. Many countries are witnessing population ageing. The proportion of the population above 60 years has been increasing. The increase in elders in a population can be attributed partly to increased life expectancy and a large measure on improved health care and health maintenance processes. The decline in the death rate and falling fertility rate are contributing to the rise of the ageing population in many developed countries (Yogesh, 2000). The problems generally faced by aged in India can be grouped as economical, medical and socio-psychological. The major problems which the new entrants to the group of 'elders' face are loss of employment, economic dependence and loss of social status (Pushpa, 2000). Because of recent demographic changes resulting in an increasing number of elderly persons in the population, institutions for elders, which were once considered a social stigma, are now being viewed as the basic right of every elderly person.

Institutions for the elderly have become an inevitable option for caring the old parents. The old age homes provide basic needs for their inmates like food, shelter and clothes. Some homes provide extra facilities for an additional fee. Based on physical, psychological, social and environmental conditions, the level of satisfaction differs from one inmate to another. The problems faced by aged persons are multiple and multidimensional such as medical, socio-economical, emotional, psychological, rehabilitative and social security problems. They become economically dependent on family for their basic needs and health care. Given the rapid changes in the family (structurally and functionally), need for institutional care is becoming more prominent in the big cities like cosmopolitan city of Chennai, which is more urbanized and greatly affected with the consumerist culture and varied market forces. The emergence of a need for institutional care cannot be addressed by the government alone; it would require a big role of private and corporate sectors and NGOs. Such need is likely to change the existing colour of old age homes which was initially meant for destitute elderly.

With the increasing elder's population, the number of persons institutionalized also will be increasing. There is a lack of research on life satisfaction of elderly people living in old age homes as most victims are frightened and unwilling to speak out. In this context, the present study is an attempt to fill some of the gaps in the study of the elderly population and the existing institutional support available to them.

The present study is also undertaken with the overall goal of understanding the socio-economic background of the elderly people and to assess the life satisfaction, living environment, socio-economic support and health status of the elderly people living in old age homes in Tamilnadu.

According to geriatric census report, around 73% belonged to the age group of above 65 years old were having a majority of health problems such as hypertension followed by arthritis, diabetes, asthma, cataract and anaemia. About 68% of the patients said that the attitude of people towards the elderly was that of neglect. In recent years, physicians and other health care workers have increasingly specialized in the field of medicine dealing with elderly patients called geriatrics. As age increases, there is a decline in the function of virtually every organ system. Some medical authorities believe that starting at age 30; there is a 1% decrease in organ function per year. This can make it difficult to distinguish between a normal decrease in organ function due to ageing and a decrease caused by an acute condition.

The older adult's population is currently the fastest-growing segment of the nation. Concern for the rapidly increasing ageing population is an international dilemma. Nearly 36% of all emergency medical calls involve the elderly. Therefore healthcare workers need to be familiar with the health care considerations for this age group. Hence, nurse who cares for older adults must be aware of the unique physical, psychological, legal, ethical and economic issues surrounding the ageing process. However, the senior citizens, referred to as elders, face certain problems as a consequence of the social transformation. This is reflected in the transition from the traditional ways of life to modern patterns, which require many compromises and adjustments. One of these involves old age homes (OAHs).

What is the genesis of old age homes and how have they changed life patterns for the elders? These questions need to be examined dispassionately. To understand the concept of OAHs, one has to go back in time five to six decades to see the life pattern of elders and chronologically trace the developments that led to the slow yet steady changes that were necessitated by circumstances. There was the much-acclaimed joint family or extended family system wherein elders lived with not only their children but also with their brothers, sisters, uncles and aunts in nearby houses,

mostly in villages or in small towns. They all used to live close, by helping each other for many purposes, in small events or in big occasions like marriages.

Everyone was close at hand for any emergencies such as health problems or deaths. Thus, the social fabric was well-woven and due respect was given to elders. This system enabled elders to lead reasonably happy lives with hardly any tension, as they had the confidence that someone would take care of them when needed. Whenever there were some health issues for an elder, the whole family would run around to attend all the needs, rendering medical to personal assistance. With perfect understanding of caring and sharing their duties, the elders did not feel the loneliness. Another major blessing in those days was the system of a 'family doctor', each family would have a friendly physician who would be ready to visit houses whenever someone was unwell. Besides medical attention, the doctor would instill confidence with pleasant words of encouragement, which would often cure the illness. Thus, a close, well-knit family system served wonderfully the elders in particular and all others in times of need. In those days when most of the deliveries used to be at home, the doctor was easily available to attend to the woman members of the family.

1.3 Objectives of the study

The major objectives of this research work are;

1) To understand the socio-economic background of the elderly people living in old age homes in Tamilnadu
2) To find out the life satisfaction of inmates in old age homes
3) To identify the living environment of inmates in old age homes
4) To assess the socio-economic support received by the inmates
5) To analyse the health status of inmates and the requirement of medical aids and substances in old age homes

1.4 Hypotheses

To obtain the objectives of the research following hypotheses were formulated;

1) There would be a significant relationship between life satisfaction and gender of elderly people in old age homes

2) There would be a significant relationship between life satisfaction and type of old age homes
3) There would be a significant relationship between life satisfaction and accessibility of medical facilities in old age homes
4) There would be a significant relationship between the living environment and type of old age homes
5) There would be a significant relationship between family support and life satisfaction of elderly people
6) There would be a significant relationship between the health status of elderly people and gender
7) There would be a significant relationship between the health status of elderly people and type of old age homes

1.5 Demographic profile of the elderly

A recent study about the elderly in the developing world is due to their increasing numbers and deteriorating conditions. While their increasing number is attributed to demographic transition, their deteriorating condition is considered as the result of the fast-eroding traditional family system in the wake of rapid modernization and urbanization. Population ageing involves a shift from high mortality/high fertility to low mortality/low fertility and consequently an increased proportion of older people in the total population.

1.5.1 World scenario

Population ageing had far-reaching effects, especially in developing countries. It was a fertility decline that caused shrinkage of the younger population while the older population increased. In Europe or developed countries, this happened very slowly since a decline in fertility was spread over a century or so. The changing proportions of the aged have been accompanied by a steady decline in the proportions of children. Over the half-century, the proportion of children (0-14 years) dropped worldwide from 34.3 per cent in 1950 to 30 per cent in 2000. In the MDRs the proportion of persons aged 60 years and above is slightly higher than the proportion of children below 15 years of age. Among the estimated population of over 10 crores in the country in the age range of 65 and above, at least 10% to 20% will be above 75 who

face health problems to different degrees. Due to personal compulsions many have emigrated and stayed with children mostly in the United States. But some are unable to travel owing to health reasons such as immobility or other personal reasons and go in search of OAHs.

Table 1.1

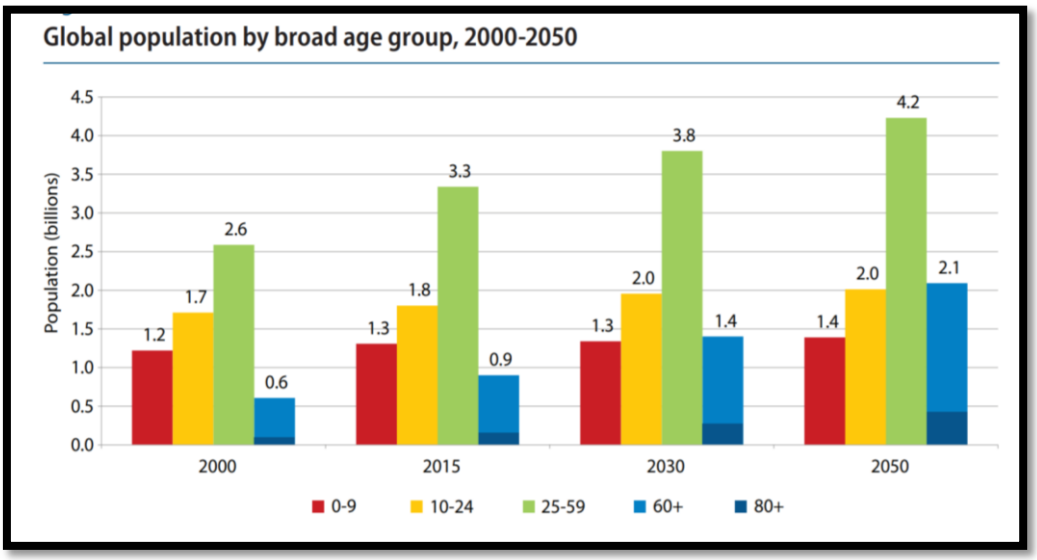
Number and distribution of persons aged 60 years or over by region, 2015 and 2030

	Persons aged 60 years or older in 2015 (millions)	Persons aged 60 years or over in 2030 (millions)	Percentage change between 2015 and 2030	Distribution of older persons in 2015 (per cent)	Distribution of older persons in 2030 (per cent)
World	900.9	1402.4	55.7	100.0	100.0
Africa	64.4	105.4	63.5	7.2	7.5
Asia	508.0	844.5	66.3	56.4	60.2
Europe	176.5	217.2	23.1	19.6	15.5
Northern America	74.6	104.8	40.5	8.3	7.5
Latin America and the Caribbean	70.9	121.0	70.6	7.9	8.6
Oceania	6.5	9.6	47.4	0.7	0.7

Source: United Nation –World Population Ageing 2015

The global population aged 60 years and above were over numbered 962 million in 2017, more than twice as large as in 1980 when there were 382 million older persons worldwide. The number of older persons is expected to double again by 2050 when it is projected to reach nearly 2.1 billion (World population ageing, UN New York, 2017). In 2030, older persons are expected to outnumber children under age 10 (1.41 billion versus 1.35 billion); in 2050, projections indicate that there will be older persons aged 60 or over than the adolescents and youth at the ages of 10-24 (2.1 billion versus 2.0 billion). Globally, the number of persons aged 80 years or over is projected to increase more than threefold between 2017 and 2050, rising from 137 million to 425 million. Two-thirds of the world's older persons live in the developing regions, where their numbers are growing faster than in the developed regions.

Chart 1.1



Source: United Nation –World Population Ageing, 2015

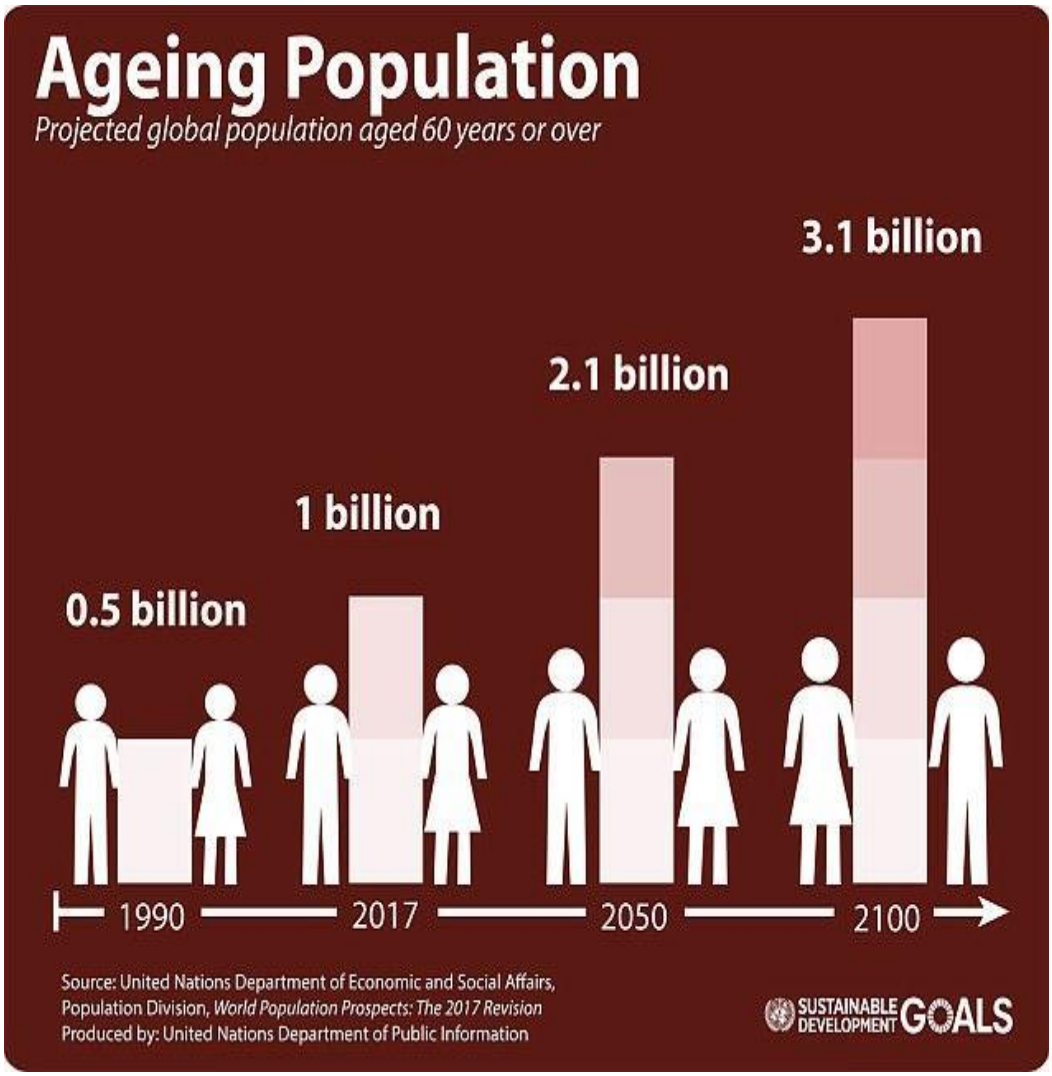
In 2050, it is expected that nearly 8 in 10 of the world's older persons will be living in the developing regions. Population ageing, the inevitable increase in the share of older persons that results from the decline in fertility and improvement in survival that characterizes the demographic transition, is occurring throughout the world. Each of the 201 countries or areas with at least 90,000 inhabitants in 2017 is projected to see an increase in the proportion of persons aged 60 or over between 2017 and 2050.

Although the process of population ageing is most advanced in Europe and in Northern America, where more than one person in five was aged 60 or over in 2017, the populations of other regions are growing older as well. In 2050, older persons are expected to account for 35 per cent of the population in Europe, 28 per cent in Northern America, 25 per cent in Latin America and the Caribbean, 24 per cent in Asia, 23 per cent in Oceania and 9 per cent in Africa. Across 143 countries with available data, the proportion of persons aged 60 and above who live 'independently' alone or with a spouse only varied widely, ranging from a low of 2.3 per cent in Afghanistan to a high of 93.4 per cent in the Netherlands.

In Asia, Africa, Latin America and the Caribbean, over half of the persons aged 60 or over co-resided with a child circa 2010; by contrast, in Europe and North

America only around 20 per cent of older persons co-resided with their children. In general, older women are more likely than older men to live alone. Both in Africa and Europe, older women were more than twice as likely as their male counterparts to be living alone. Data for 67 countries indicate that older persons have become more likely in recent decades to live independently, whereas co-residence with children has become less common.

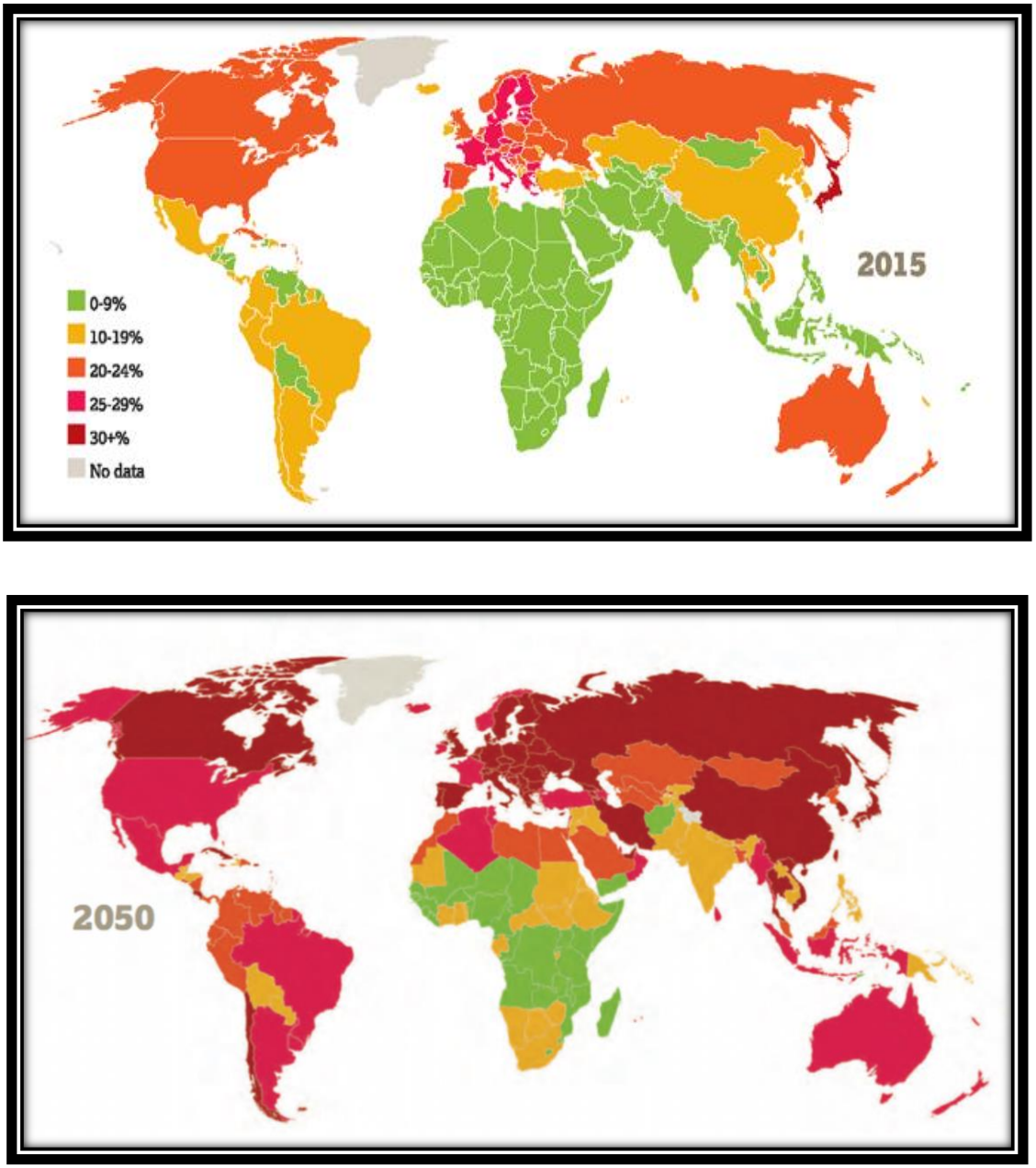
Figure 1.1



According to data from World Population Prospects: the 2019 Revision, by 2050, one in six people in the world will be over age 65 (16%), up from one in 11 in 2019 (9%). By 2050, one in four persons living in Europe and Northern America could be aged 65 or over. In 2018, for the first time in history, persons aged 65 and above

outnumbered children under five years of age globally. The number of persons aged 80 years or over is projected to triple, from 143 million in 2019 to 426 million in 2050.

Figure 1.2: Global population aged 60 years and over, 2015 and 2050 (Projected)



Source: Global Age Watch Index, 2015, Help Age International

Population ageing is a global phenomenon. Virtually every country in the world is experiencing growth in both the size and the proportion of older persons in the population. In 2019, there were 703 million persons aged 65 years or over in the global

population. This number is projected to double to 1.5 billion in 2050. Globally, the share of the population aged 65 years or over increased from 6 per cent in 1990 to 9 per cent in 2019. That proportion is projected to rise further to 16 per cent in 2050, when it is expected that one in six people worldwide will be aged 65 years or over.

Globally, the number of persons aged 80 years or older nearly tripled between 1990 and 2019, growing from 54 million to 143 million; it is projected to triple again between 2019 and 2050 to reach 426 million. Between 1990 and 2019, the number of persons aged 80 or over doubled in all regions except Europe and Northern America and tripled in four of eight regions. Between 2019 and 2050, the number of persons aged 80 years or over is projected to show the largest percentage increases in Eastern and South-Eastern Asia and Northern Africa and Western Asia. (world population ageing,2020).

As a result of the gender gap in longevity, older women currently outnumber older men across the age range in particular, for those aged 80 years or older. Globally in 2019, there were 81 men for every 100 women aged 65 years or older, yet only 63 men for every 100 women aged 80 years or older. With the sex difference in longevity expected to narrow in future years, in 2050 it is projected that there will be 85 men per 100 women aged 65 years or over, and 71 men per 100 women at ages 80 and above.

1.5.2 Population of elderly in India

In India, as a result of the change in the age composition of the population over time, there has been a progressive increase in both the number and proportion of aged the people. The Indian population has increased from 361 million in 1951 to 1.02 billion in 2001 and further to 1.21 billion in 2011. Simultaneously, the number of older people has increased from 19 million (i.e. 4 per cent of the total population) to 77 million and further to 93 million (i.e. 7.5 per cent of the total) during the same period (Registrar General of India, SRS 2011). According to the 2011 Census of India, there has been a steady rise in the share of the elderly population (aged 60 years or above) in the total population over the decades. The proportion of elderly people in the population of India raised from 5.6 per cent in 1961 to 7.5 per cent in 2001.

Table 1.2 Elderly population in India

Population aged 60+ (in million)	Male	Female	Total
Rural	36.0	37.3	73.3
Urban	15.1	15.5	30.6
Total	51.1	52.8	103.9
Share of the elderly population in total population (%)			
Rural	8.4	9.2	8.8
Urban	7.7	8.5	8.1
Total	8.2	9.0	8.6
Old-age dependency ratio			
Rural	14.5	15.8	15.1
Urban	11.8	13.1	12.4
Total	13.6	14.9	14.2
Life expectancy 60 +			
Total	16.9	19.0	17.9
Death rate (60-64 years) (per 1000)			
Rural	22.3	17.2	19.7
Urban	16.6	13.4	15.0
Total	20.7	16.1	18.4
Literacy rate 60+			
Rural	50.5	18.4	34.2
Urban	79.6	52.7	66.0
Total	59.1	28.5	43.5
Sources: Population census 2011, SRS Report 2013			

According to Population Census 2011, there are nearly 104 million elderly persons in India; 53 million females and 51 million males. It is interesting to note that up to Population Census 1991, the number of elderly males exceeded the number of females. In the last two decades, however, the trend has been reversed and the elderly females outnumbered the elderly males. This is also a major concern for policymakers as elderly women are more vulnerable on all fronts compared to elderly men. As regards

rural and urban areas, more than 73 million persons i.e. 71 per cent of the elderly population reside in rural areas while 31 million or 29 per cent of the elderly population is in urban areas.

Figure 1.3

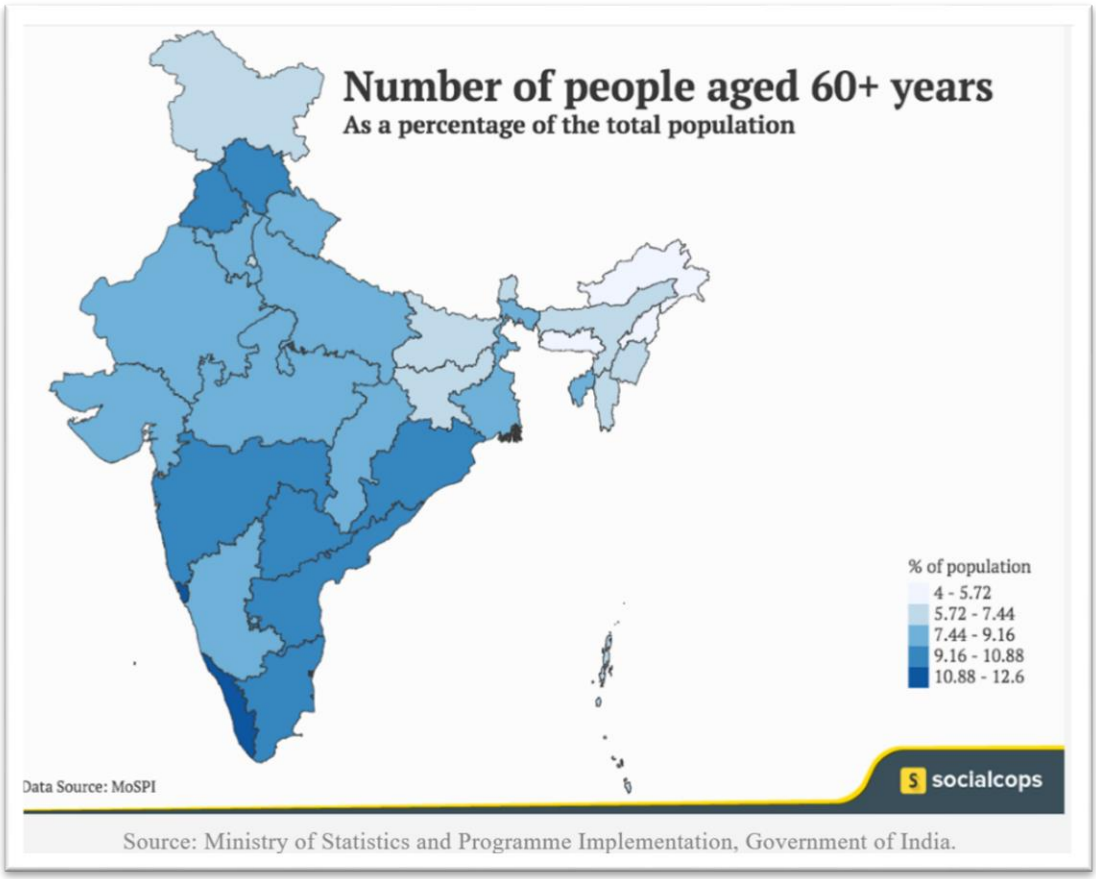

Number of people aged 60+ years
As a percentage of the total population
% of population
4 - 5.72
5.72 - 7.44
7.44 - 9.16
9.16 - 10.88
10.88 - 12.6
Data Source: MoSPI
socialcops
Source: Ministry of Statistics and Programme Implementation, Government of India.

Table 1.3 Percentage share of the elderly population (aged 60 years and above) In total population by sex in India

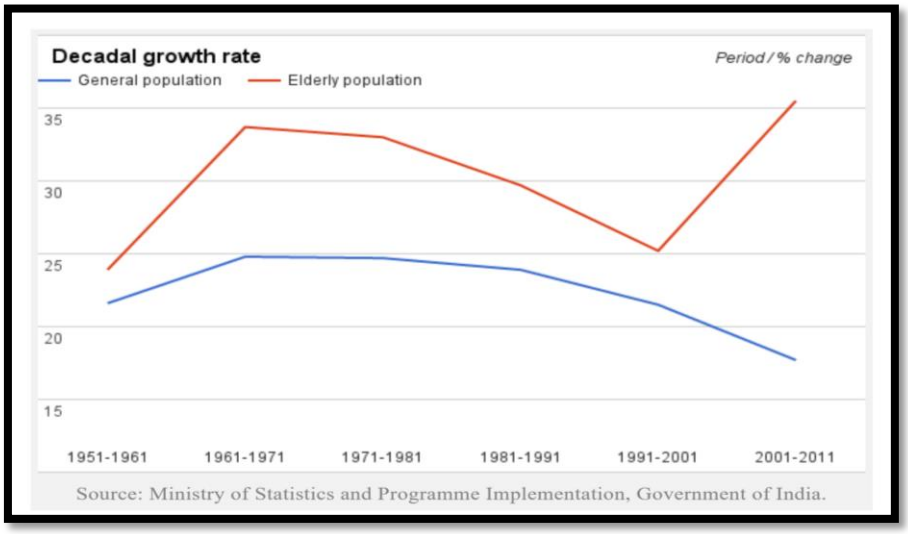
Years	Male	Female	Total	Rural	Urban
1961	5.5	5.8	5.6	5.8	4.7
1971	5.9	6.0	6.0	6.2	5.0
1981	6.4	6.6	6.5	6.8	5.4
1991	6.7	6.8	6.8	7.1	5.7
2001	7.7	7.8	7.5	7.7	6.7
2011	7.7	8.4	8.0	8.1	7.9

Source: Census of India for 1961-2001, SRS (Sample Registration System) Statistical Report 2011

The percentage share of elderly persons in the population of India is ever increasing since 1961. While in 1961, 5.6 per cent population was in the age bracket of 60 years or more, the proportion has increased to 8.6 per cent in 2011. The trend is the same in rural as well as in the urban areas. In rural areas, while the proportion of elderly persons has increased from 5.8 per cent to 8.8 per cent, in urban areas it has increased from 4.7 per cent to 8.1 per cent from 1961 to 2011. It is observed that the difference of percentage share of the elderly population in the whole population in rural and urban areas is narrowing. For 2013, the age-specific death rate per 1000 population for the age group 60-64 years was 19.7 for rural areas and 15.0 for urban areas. Altogether it was 18.4 for the age group 60-64 years. As regards, sex-wise, it was 20.7 for males and 16.1 for females.

The Old age dependency ratio shows an increasing trend and the ratio has risen from 10.9% in 1961 to 14.2% in 2011. The gap between female and male old-age dependency ratio also has an increasing trend and the two assumed the values 14.9 and 13.6 respectively in 2011. Between rural and urban ratios there has been a considerable difference in all the periods and this may be due to the relatively higher concentration of working-age population in urban areas. According to the 2011 census the old-age dependency ratios are 15.1 and 12.4 for rural and urban areas respectively. The overall literacy rate among persons aged 60 years and above was least (20%) in Arunachal Pradesh. The maximum literacy rate was 84% in Mizoram followed by 79% in Kerala and 75% in Chandigarh.

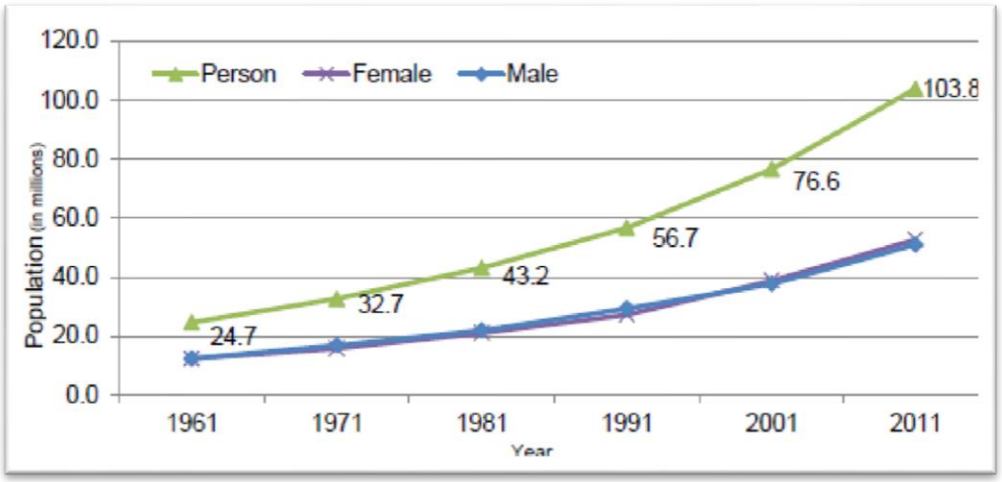
Chart 1.2



Among the elderly persons, it is observed that despite illness more men seemed to be feeling that they had a better health condition as compared to the women. In urban areas, more elderly men and women felt to have good/ fair health as compared to their counterpart in the rural areas. The prevalence of heart diseases among elderly men and women was much higher in more aged women reported suffering from the problem of joints. Urinary problems were more common among aged men while urban areas than in rural areas.

The growth in the elderly population is due to the longevity of life achieved because of economic well-being, better medicines and medical facilities and reduction in fertility rates. In India, the decadal growth in the general population has shown a decreasing trend since 1961 and so is the growth in the elderly population till 2001. In the last decade, however, that is between 2001 and 2011; the growth in the elderly population has shot up to 36 per cent while the same was 25 per cent in the earlier decade. The general population has grown by merely 18 per cent vis-à-vis 22 per cent in the earlier decade. It is observed that in India, the growth in the elderly population has always been more than the growth in the general population. The very high growth rate in the elderly population vis-à-vis of the general population was observed earlier also in the two decades between 1961 and 1981.

Chart 1.3 Elderly Populations in India



Population Census 2011 data reveals that locomotor disability and visual disability are the most prevalent disabilities among elderly persons. Almost half of the

elderly disabled population was reported to be suffering from these two types of disabilities. Percentage of elderly disabled persons is slightly higher in rural areas as compared to urban areas as per Census 2011 Data. 6% of the elderly population was reported as disabled in rural areas whereas; in urban areas 4% of the elderly population was disabled. The population Census 2011 data shows that the percentage of currently married elderly women was markedly lower than the percentage of currently married elderly men. After the age of 70 years, more than 60% of women become widows.

Table 1.4 Size of the elderly population (aged 60+) and their share in total population in major states of India in 2011

All India and selected major states	The proportion of elderly in a total population of State		
	Male	**Female**	**Total**
Andhra Pradesh	8.3	9.4	8.8
Bihar	7.2	6.7	7.0
Himachal Pradesh	10.4	10.3	10.4
Karnataka	7.9	8.9	8.4
Kerala	11.8	13.3	12.6
Maharashtra	8.8	9.7	9.3
Rajasthan	6.6	7.9	7.2
Tamilnadu	10.2	10.9	10.5
West Bengal	8.2	8.2	8.2
All India	**7.7**	**8.4**	**8.0**

Source: SRS Bulletin (Sample Registration System) October 2012, Registrar, General of India, New Delhi

Among the states, (Table 1.4) the proportion of elderly in the total population was more than 9 per cent in Maharashtra, Tamil Nadu and Himachal Pradesh. In Kerala, the proportion of elderly in a total population of the state was highest (12.6 per cent) in the year 2011. Secondly, regarding feminization of the elderly population, it has been found that elderly female outnumbered elderly male in almost every state except Bihar, Haryana, Punjab and Uttar Pradesh.

According to SRS statistical report, elderly population in 2011 rose further to 8.0 per cent. The gender-wise distribution of aged (60+) in the total population for different states has been shown in Table 1.4. Two interesting observations have been observed, first regarding inter-state variation in the size distribution of the elderly population, it has been observed that the share of aged population in most of the states exceed than all India level (8.0 per cent). This was particularly true for Kerala, Himachal Pradesh, Maharashtra, Punjab, Tamil Nadu, Odisha and Karnataka.

1.5.3 Demographic profile of Tamil Nadu

Tamil Nadu is one of the 28 states of India (India.gov 2020). It lies on the eastern coast of the southern Indian peninsula bordered by Puducherry, Kerala, Karnataka and Andhra Pradesh. Tamil Nadu is bound by the Eastern Ghats in the north, the Nilgiris, the Annamalai Hills, and Palakkad on the west, the Bay of Bengal in the east, Gulf of Mannar, Palk Strait in the south-east and the Indian Ocean in the south.

According to Census 2011, the state's population was 72 million (7,21,38,958). It is the seventh most populous state in the country. Except for Kerala, Tamilnadu recorded the lowest population growth rate in 1991-2001 among all the states and Union territories in India. The decadal (2001-2011) growth rate was 15.60 per cent. The population sex ratio, defined as the number of females per 1000 males in the population, works out to 995 in 2011 compared to 987 in 2001 and 974 in 1991. However, the child sex ratio, defined as the number of girls per 1000 boys in the age group of 0-6 years, has gone up from 942 in 2001 to 946 in 2011.

The density of the population was 555 persons per sq. km in 2011 against 478 in 2001 and 429 in 1991. Life expectancy is projected to be 65.2 years for males and 67.6 years for females. Tamilnadu is today the most urbanized state in India with 48 per cent of the population living in urban areas. Tamilnadu urban slum population in 2001 census was 2.9 million, which was 10.6% of the total urban population of the State. More than 30% of Chennai’s populations live in slums.

Tamil Nadu has the highest proportion (2018) of the elderly (10%) next to Kerala, which has 11%. It is third when it comes to the absolute number of elderly people, nearly 60 lakh, after Uttar Pradesh with 1.2 crores and Maharashtra with nearly

86 lakh. Even among the metros, Chennai has the second-highest proportion of elderly (8%), next only to Kolkata (10%). The statistics indicate a growing need to cater to the special needs of the elderly in Tamil Nadu, given the fact that so many of them have nobody to take care of them at home.

Table 1.5 Population Profile by Districts of Tamilnadu

Districts	Population (2011)	Sex Ratio (2011)	Child Sex Ratio (2011)
TAMIL NADU	68515977	987	942
Chennai	4681087	986	964
Kancheepuram	3990897	985	967
Vellore	3928106	1004	944
Thiruvallur	3725697	983	954
Salem	3480008	954	917
Coimbatore	3472578	1001	963
Villupuram	3463284	985	938
Tirunelveli	3072880	1024	964
Madurai	3041038	990	939
Tiruchirapalli	2713858	1013	952
Cuddalore	2600880	984	895
Tiruppur	2471222	988	951
Tiruvannamalai	2468965	993	932
Thanjavur	2402781	1031	957
Erode	2259608	992	956
Dindigul	2161367	998	942
Virudhunagar	1943309	1009	962

	Krishnagiri	1883731	956	924
	Kanyakumari	1863174	1014	961
	Thoothukudi	1738376	1024	970
	Namakkal	1721179	986	913
	Pudukottai	1618725	1015	959
	Nagapattinam	1614069	1025	961
	Dharmapuri	1502900	946	911
	Sivagangai	1341250	1000	961
	Ramanathapuram	1337560	977	967
	Thiruvarur	1268094	1,020	962
	Theni	1243684	990	937
	Karur	1076588	1015	946
	Ariyalur	752481	1016	892
	The Nilgiris	735071	1041	982
	Perambalur	564511	1006	913

Table 1.6 Demographic particulars of Tamilnadu

Area (Sq. Km)	130058
Districts	32
Taluks	220
Community Development Blocks	385
Gram Panchayaths	12618
Revenue Villages	17244
Town Panchayaths	561
Municipalities	125

Municipal Corporations	10
Cantonments	2
Population	72138958
Males	31400909
Females	31004770
Rural (%)	73.9
Urban (%)	26.1
Scheduled Castes (%)	19.0
Scheduled Tribes (%)	1.0
Elderly Population (60+ years) (%)	8.8
Young people (10-24 years) (%)	28.8
Population density (per sq. km)	480
Sex Ratio (females per 1000 males)	987
Child Sex Ratio (0-6 years) (girls per 1000 boys)	942

Table 1.7 Highly populated districts in Tamilnadu (2011)

District	Population	Area (km2)	Po. Density	Sex-ratio
Chennai	4646732	175	26553	989
Kancheepuram	3998252	4483	892	986
Vellore	3936331	6075	648	1007
Thiruvallur	3728104	3394	1098	987

In this research, a field study was conducted in the first four highly populated districts (census 2011) in Tamilnadu. They are Chennai, Kancheepuram, Vellore and Thiruvallur.

a) The Chennai Metropolitan Area is one of the largest city economies of India. Chennai is nicknamed ‘The Detroit of India’, with more than one-third of India's automobile industry being based in the city. In January 2015, it was ranked third in terms of per capita GDP. Chennai has been selected as one of the 100 Indian cities to be developed as a smart city under PM Narendra Modi's flagship Smart Cities Mission. According to UN Mega Cities 2016 report, Chennai is ranked at number 30 in the most populous urban agglomeration in the world.

b) According to the 2011 census, the Kancheepuram district had a population of 39.99 lakh, which was about 5.53% of the total state population. The total population of the district was 39,98,252 in which 20,12,958 were male and 19,85,294 were female. In rural 14,59,916 and in urban it was 25,38,336.

c) Vellore district was one of the 32 districts (2018) in the Tamil Nadu state of India. It is one of the six districts from North region of Tamil Nadu. Vellore City is the headquarters of this district. As of 2011, the district had a population of 3,936,331 with a sex ratio of 1,007 females for every 1,000 males. The Government of India recently included Vellore city into prestigious smart City project along with 26 more cities.

d) Thiruvallur District is an administrative district in the South Indian state of Tamil Nadu. The town of Thiruvallur is the district headquarters. The district has a mixture of urban and rural characteristics. As of 2011, the district had a population of 3,728,104 with a sex-ratio of 987 females for every 1,000 males. The district has been divided into four revenue divisions viz, Thiruvallur, Tiruttani, Ambattur and Ponneri.

1.6 Concepts and definitions

a) Elderly people

Elderly or old age consists of ages nearing or surpassing the average life span of human beings. The boundary of old age cannot be defined exactly because it does not have the same meaning in all societies. Government of India adopted ‘National Policy on Older Persons’ in January 1999. The policy defines ‘senior citizen’ or ‘elderly’ as a person who is of age 60 years and above.

b) Life Expectancy

Life expectancy is the expected (in the statistical sense) number of years of life remaining at a given age. It is denoted by ex, which means the average number of subsequent years of life for someone now aged x, according to a particular mortality experience. (In technical literature, this symbol means the average number of complete years of life remaining, excluding fractions of a year). These are based on life table derived by comparing the population p(1)x at age x in one census with their survivors reported at age p(2)x+10 in the next census. From the 10 years survival ratios for individual years have been estimated. For younger and older ages, special methods have been adopted. With these survival ratios (px) and smoothed- age data, mortality rates (px) are worked out and the life table is prepared. The life tables are also prepared with the age-specific death-rates obtained by the Sample Registration System.

c) Death Rate

The death rate is a measure of the number of deaths in some population, scaled to the size of that population, per unit time. The death rate is typically expressed in units of deaths per 1000 individuals per year; thus, a death rate of 9.5 in a population of 100,000 would mean 950 deaths per year in that entire population or 0.95% out of the total.

d) Dependency ratio

The dependency ratio is an age-population ratio of those typically not in the labour force (the dependent part) and those typically in the labour force (the productive part). It is used to measure the pressure on the productive population and is normally expressed as a percentage. In international statistics, the dependent part usually includes those under the age of 15 and over the age of 64. The productive part makes up the population in between, ages 15 to 64. It is normally expressed as a percentage.

e) Old age dependency ratio (In India)

The (total) dependency ratio can be decomposed into the child dependency ratio and the old-age dependency ratio. Old-Age Dependency Ratio in India, generally, persons aged 15 to 59 years are supposed to form the population of working ages and at

age 60, people generally retire or withdraw themselves from work. Thus, the Old-age dependency ratio is defined as the number of persons in the age-group 60 or more per 100 persons in the age-group 15 to 59 years.

f) Economic Independence

A person is considered economically independent if he/she does not require taking financial help from others to live a normal life. Monthly Per capita Consumption Expenditure (MPCE) for a household, this is the total consumer expenditure over all items per month (30 days basis) divided by the size of the household. A person's MPCE is taken as that of the household to which he or she belongs. From the data on the NSSO Consumer Expenditure Survey, these MPCE classes are obtained separately for rural and urban part of the country.

g) Quality of life

The concept of quality of life is frequently used to describe the good life within several disciplines such as economy, sociology, psychology, medicine, and health-care. The contents and specific measures of quality of life, however, vary both between and within disciplines (Farquhar, 1995). The emphasis ranges from standards of living in the economy to perceived health status in medicine. More than 1000 measures of various aspects of quality of life have been identified and more than 100 definitions of quality of life have been proposed (Cummins, 1997).

Despite the lack of a widely accepted definition, most definitions of quality of life include a multidimensional functional status aspect and a subjectivity aspect (Muldoon, Barger, Flory, & Manuck, 1998). Multidimensional functional status incorporates physical well-being, functional ability, emotional well-being, social well-being and subjectivity refers to the individual's perception of his or her quality of life (Muldoon et al., 1998). Accordingly, whereas the subjectivity aspect of quality of life resembles life satisfaction, there is a multidimensional functional status dimension of the quality of life concept that life satisfaction excludes.

1.7 Life satisfaction

Life satisfaction is a complex term and is sometimes used interchangeably with the emotion of happiness, but they are indeed two separate concepts. Life satisfaction is defined as one's evaluation of life as a whole, rather than the feelings and emotions that are experienced at the moment. The sources of life satisfaction are not completely understood yet, but what is known, is that they are a complex combination of, a) collective action, b) individual behaviour, c) simple sensory experiences, d) higher cognition, e) stable characteristics of the individual, f) the environment and g) chance factors.

Variance in satisfaction between nations has been studied; it has been shown that living conditions are a major determinant of life satisfaction. That is, economically prosperous countries tend to experience it more when compared to poorer nations. The correlation between income and life satisfaction is higher in poorer countries compared to more affluent countries. Life satisfaction tends to be higher in egalitarian countries; people will experience less inequality and be able to choose lifestyles that best fit their abilities and desires where equality is more prominently displayed.

As pointed-out from the variance in satisfaction between nations' resource, more highly educated countries generally experience higher levels of satisfaction, but with this education comes an opportunity for aversive consequences: loss of previous opportunities that come along with achieving such education, job competition, or even lack of jobs. That being said, those more educated tend to experience more favourable events compared to adverse events. Variables such as mental and physical health, energy, extroversion, and empathy have all been shown to be strongly correlated to satisfied individuals, but it is sometimes hard to determine whether these are products or causes of life satisfaction. Our past experiences undoubtedly affect the way we think about our lives in terms of satisfaction.

In the beginning of 1960s when it became a big topic of discussion in research, life satisfaction was originally thought to be measured objectively and externally; the same way measuring heart-rate or blood pressure would be. Since then, it has become evident that life satisfaction must be measured subjectively rather than objectively; techniques commonly used include surveys, questionnaires, and interviews.

Measuring life satisfaction is not just a way to see how *happy* people are with their lives; it is also a way of determining how *unhappy* they are. By adding another, positive point of view stemming from the individuals' subjective experience, clinicians and researchers can analyze what makes people happy and what makes them unhappy.

The Satisfaction with Life Scale (SWLS), created by Ed Diener, has been one of the more applicable measurement tests of life satisfaction. It consists of five statements (e.g. The conditions of my life are excellent) to which the participant indicates their agreement. This assessment doesn't specify explicit domains such as financial or health satisfaction; it allows subjective evaluation of life as a whole. In this research work, two scales have been used to evaluate the life satisfaction of elderly people living in old age homes. They are;

1) Satisfaction with life scale (SWLS) – 5 Items
2) Oxford happiness questionnaire (OHQ) – 29 items

1.7.1 Satisfaction with life scale (SWLS)

According to the research conducted on the validity of life satisfaction scales, one of the main measurements is based on preferences and values of people (Diener, Inglehart & Tay, 2013). Satisfaction with Life Scale (SWLS) is a short 5-items instrument designed to measure global cognitive judgments with life. Below are five statements that may agree or disagree with. Using the 1 - 7 scale, indicate agreement with each item by placing the appropriate number on the line preceding that item.

Sl.no	**Statements**	**S.A**	**A**	**SL.A**	**N.A**	**SL.D**	**D**	**S.D**
1	In most ways, my life is close to my ideal.							
2	The conditions of my life are excellent							
3	I am satisfied with my life							
4	So far I have gotten the important things I want in life							
5	If I could live my life over, I would change almost nothing							
S.A- Strongly agree-7, **A**-Agree-6, **SL.A**-Slightly agree-5, **N.A**-Neither agree nor disagree-4, **SL.D**-Slightly disagree-3, **D**-Disagree-2, **S.D**-Strongly disagree-1.								

a) Score 30 – 35: Very high score; highly satisfied

Respondents who score in this range love their lives and feel that things are going very well. Their lives are not perfect, but they feel that things are about as good as lives get. Furthermore, just because the person is satisfied does not mean she or he is complacent. Growth and challenge might be part of the reason the respondent is satisfied. For most people in this high-scoring range, life is enjoyable, and the major domains of life are going well – work or school, family, friends, leisure, and personal development.

b) Score 25- 29: High score

Individuals who score in this range like their lives and feel that things are going well. Of course, their lives are not perfect, but they feel that things are mostly good. Furthermore, just because the person is satisfied does not mean she or he is complacent. Growth and challenge might be part of the reason the respondent is satisfied. For most people in this high-scoring range, life is enjoyable, and the major domains of life are going well – work or school, family, friends, leisure, and personal development. The person may draw motivation from the areas of dissatisfaction.

c) Score 20 – 24: Average score

The average of life satisfaction in economically developed nations is in this range the majority of people is generally satisfied but has some areas where they very much would like some improvement. Some individuals score in this range because they are mostly satisfied with most areas of their lives but see the need for some improvement in each area. Other respondents score in this range because they are satisfied with most domains of their lives, but have one or two areas where they would like to see large improvements. A person scoring in this range is normal in that they have areas of their lives that need improvement. However, an individual in this range would usually like to move to a higher level by making some life changes.

d) Score 15 – 19: Slightly below average

People who score in this range usually have small but significant problems in several areas of their lives or have many areas that are doing fine but one area that

represents a substantial problem for them. If a person has moved temporarily into this level of life satisfaction from a higher level because of some recent event, things will usually improve over time and satisfaction will generally move back up. On the other hand, if a person is chronically slightly dissatisfied with many areas of life, some changes might be in order. Sometimes the person is simply expecting too much, and sometimes life changes are needed. Thus, although temporary dissatisfaction is common and normal, a chronic level of dissatisfaction across some areas of life calls for reflection. Some people can gain motivation from a small level of dissatisfaction, but often dissatisfaction across some life domains is a distraction, and unpleasant as well.

e) Score 10 – 14: Dissatisfied

People who score in this range are substantially dissatisfied with their lives. People in this range may have some domains that are not going well or one or two domains that are going very badly. If life dissatisfaction is a response to a recent event such as bereavement, divorce, or a significant problem at work, the person will probably return over time to his or her former level of higher satisfaction. However, if low levels of life satisfaction have been chronic for the person, some changes are in order – both in attitudes and patterns of thinking and probably in life activities as well. Low levels of life satisfaction in this range, if they persist, can indicate that things are going badly and life alterations are needed. Furthermore, a person with low life satisfaction in this range is sometimes not functioning well because their unhappiness serves as a distraction. Talking to a friend, member of the clergy, counsellor, or other specialists can often help the person get moving in the right direction, although positive change will be up the person.

f) Score 5 – 9: Extremely Dissatisfied

Individuals who score in this range are usually extremely unhappy with their current life. In some cases, this is in reaction to some recent bad event such as widowhood or unemployment. In other cases, it is a response to a chronic problem such as alcoholism or addiction. In yet other cases the extreme dissatisfaction is a reaction due to something bad in life such as recently having lost a loved one. However, dissatisfaction at this level is often due to dissatisfaction in multiple areas of life. Whatever the reason for the low level of life satisfaction, it may be that the help of

others is needed – a friend or family member, counselling with a member of the clergy, or help from a psychologist or other counsellor. If the dissatisfaction is chronic, the person needs to change, and often others can help.

To understand life satisfaction scores, it is helpful to understand some of the components that go into most people's experience of satisfaction. One of the most important influences on happiness is social relationships. People who score high on life satisfaction tend to have close and supportive family and friends, whereas those who do not have close friends and family are more likely to be dissatisfied. Of course, the loss of a close friend or family member can cause dissatisfaction with life, and it may take quite a time for the person to bounce back from the loss. Another factor that influences the life satisfaction of most people is work or school, or performance in an important role such as homemaker or grandparent. When the person enjoys his or her work, whether it is paid or unpaid work, and feels that it is meaningful and important, this contributes to life satisfaction. When work is going poorly because of bad circumstances or a poor fit with the person's strengths, this can lower life satisfaction. When a person has important goals and is failing to make adequate progress toward them, this too can lead to life dissatisfaction.

A third factor that influences the life satisfaction of most people is personal – satisfaction with the self, religious or spiritual life, learning and growth, and leisure. For many people, these are sources of satisfaction. However, when these sources of personal worth are frustrated, they can be powerful sources of dissatisfaction. Of course, there are additional sources of satisfaction and dissatisfaction – some that are common to most people such as health, and others that are unique to each individual. Most people know the factors that lead to their satisfaction or dissatisfaction, although a person's temperament – a general tendency to be happy or unhappy – can colour their responses.

1.7.2 Oxford Happiness Questionnaire

Oxford happiness questionnaire was developed (2002) by psychologists Michael Argyle and Peter Hills at Oxford University. Below are statements about happiness to indicate how much people agree or disagree. (Some of the questions are phrased positively and others negatively)

Oxford Happiness Questionnaire

Sl. no	Questions		ST.D	MO.D	SL.D	SL.A	MO.A	ST.A
1	I don't feel particularly pleased with the way I am.	R						
2	I am intensely interested in other people.							
3	I feel that life is very rewarding.							
4	I have very warm feelings towards almost everyone.							
5	I rarely wake up feeling rested.	R						
6	I am not particularly optimistic about the future.	R						
7	I find most things amusing.							
8	I am always committed and involved.							
9	Life is good.							
10	I do not think that the world is a good place.	R						
11	I laugh a lot.							
12	I am well satisfied with everything in my life.							
13	I don't think I look attractive.	R						
14	There is a gap between what I would like to do and what I have done.	R						
15	I am very happy.							
16	I find beauty in some things.							
17	I always have a cheerful effect on others.							
18	I can fit in (find time for) everything I want to.							

19	I feel that I am not especially in control of my life.	R						
20	I feel able to take anything on.							
21	I feel fully mentally alert.							
22	I often experience joy and elation.							
23	I don't find it easy to make decisions.	R						
24	I don't have a particular sense of meaning and purpose in my life.	R						
25	I feel I have a great deal of energy.							
26	I usually have a good influence on events.							
27	I don't have fun with other people.	R						
28	I don't feel particularly healthy.	R						
29	I don't have particularly happy memories of the past	R						
Note: The R (Reverse scored) notation is related to mathematics at the end of the questions. **ST.D**-Strongly disagree-1, **MO.D**-Moderately disagree-2, **SL.D**-Slightly disagree-3, **SL.A**-Slightly agree-4, **MO.A**-Moderately agree-5, **ST. A**-Strongly agree-6.								

Step 1. Items marked (R) should be scored in reverse: For example, change 1 to a 6, Change 2 to a 5, Change 3 to a 4, Change 4 to a 3, Change 5 to a 2 and Change 6 to a 1.

Step 2. Add the numbers for all 29 questions. (Use the converted numbers for the 12 ite ms that are reverse scored.)

Step 3. Divide by 29. So your happiness score = the total (from step 2) divided by 29.

Happiness Score: Interpreting the score, by Stephen Wright.

Score 1 to 2: **Not Happy -** If you answered honestly and got a very low score, you're probably seeing yourself and your situation as worse than it is.

Score 2 to 3: **Somewhat unhappy -**Try some of the exercises like the Gratitude Journal & Gratitude lists.

Score 3-4: **Not particularly happy or unhappy-** A Score of 3.5 would be an exact numerical average of happy and unhappy responses. Some of the exercises mentioned just above have been tested in scientific studies and have been shown to make people lastingly happier.

Score 4: **Somewhat happy or moderately happy-** This is what the average person scores.

Score 4-5: **Rather happy; pretty happy**- Check other score ranges for some of my suggestions.

Score 5-6: **Very happy-** Being happy have more benefits than just feeling good. It's correlated with benefits like health, better marriages, and attaining your goals.

Score 6: **Too happy-** Recent research seems to show that there's an optimal level of happiness for things like doing well at work or school, or for being healthy and that being 'too happy' may be associated with lower levels of such things.

1.8 Living environment

The issue of living environment preferences of the elderly especially in the context of India is a challenging subject to study. There were no serious thoughts on the issues of the elderly relating to their health, morbidity pattern, diseases pattern, and isolation, adjustment within the family, abuse, insecurity, and living environment before the 20th century. Though some studies have looked into the health of the elderly in India, the research area is still very rudimentary and nascent. The living environment is an important component in dealing with the welfare of any specific group. The elderly persons, being less able to be independent, need the care and support of others in several aspects. Taking care of the elderly refers mainly to emotional support; on the other hand, support given to the elderly refers to the financial and material support.

Some old age homes are housed in good buildings. The male and female inmates have a separate dormitory; each of the dormitories is attached with bathrooms and toilet. Facilities like cots, fan, cupboards and bed sheet are provided in every room. There are separate rooms for conducting prayer meeting, recreation room for watching TV, reading the newspaper, etc., and yet another one for dining. Special sessions on spiritual mantras, meditation and yoga are conducted in some old age homes.

Counselling for physical and mental health is given to the aged. Indoor games such as carom and chessboard, etc., are provided for recreation. A vehicle is stationed at old age home for an emergency. The aged are engaged in the kitchen, farming, ornamental dressmaking, gardening, vermin-compost, mushroom cultivation and other allied activities.

'Charitable trusts must be registered but the same rule may not apply to old age homes. Moreover, there is nobody to monitor their services. Four aspects are crucial to an old age home, namely infrastructure, services, skilled staff and participation of residents in the working of homes. Here, unfortunately, there is none. While there are some old age homes which are run extremely well, others are in a horrible condition,' said Gambhir (The Times of India, Oct 2016). According to experts, demand for retirement facilities is steadily overtaking that for old age homes. Vinod Shah, a founder of Janseva Foundation that works for the welfare of the elderly, explained that while there are enough old age homes, the demand is for retirement facilities. 'Generally, retirement facilities are designed for people from the higher economic strata of the society and there is a huge demand for it. A new facility is even coming up near Kamshet as of now. However, there is a need to improve the existing old age homes and provide better infrastructure and care,' said Shah (TOI, 2016).

Most of the old age homes offer free accommodation. Some old age homes work on a payment basis depending upon the types and quality of services offered. Apart from food, shelter and medical facilities, many old age homes also have the provision for physical exercises such as yoga to senior citizens. Old age homes also provide access to telephones and other forms of communications so that the inmates can keep in touch with their dear ones. For elderly people, who have nowhere to go and no one to support them, old age homes are a better solace. In old age homes, the inmates get the family-like atmosphere.

1.9 Socio-economic condition of the elderly in India

Old age is the later part of life, which is characterized by deterioration in physical capacities. The deterioration brings changes in the person's active participation in different areas of life, role-playing and role performance and from economic self-sufficiency to dependence. As a person moves along the life cycle to the higher age

group a general change occurs in his or her living environment. This is mainly because as the age goes up the ability of the individual to convert their endowments into output declines. The elderly person loses out their lifetime amenities as it pass through a lean period of their life (Bagchi, 2003). This section examines the socio-economic conditions of the elderly population in India.

Marital status

Marital status of the elderly assumes special significance in the context of care in old age as it is known that those who are married are far better in all economic and social aspects than those who are single. A major concern related to the increasing proportion of elderly women especially widows in the population. Two reasons are given for the marked gender disparities in widowhood in India (i) longer life span of women compared to that of men and (ii) the general tendencies in India for women to marry men older than themselves (Gulati and Irudaya Rajan 1999). Also, widowed men are much more likely to remarry and thus restore their earlier status. Though the relationship between the wellbeing of the elderly and their marital status cannot be spelt out precisely, any change in the marital status of the elderly deserves careful examination.

Economic Condition

Inadequate financial resources are mentioned as one of the major problems of the Indian elderly. The financial inadequacy seems to be of higher degree among the elderly women compared to their male counterparts. Another major problem is related to the loss of economic independence with the increase in age. The elderly continue to work through their working hours decrease with the increase in age. Financial problems are more common among widows and among the elderly who live in nuclear families. Economic insecurity is considered to be the sole concern of the elderly in barely sustainable households in India. The major sources of worry for the elderly are stress and economic dependence. For understanding their economic dependence it is important to analyse gainful employment among the elderly.

The financial and economic wellbeing of the elderly is closely linked to their level of education and past work status. Under usual circumstances, most of the

elderly in the formal sector would have retired from the labour force. However, given the Indian situation where the unorganized sector accounts for a larger share of the workforce and where rural labour is predominantly in agriculture or allied activities, there is no question of formal retirement for the elderly. Being economically active is probably a positive feature of the aged population in India since it helps to keep at bay many of the age-related health problems that arise from a feeling of being unwanted, isolated and useless.

1.10 Health status of Elderly

The process of biological ageing brings with it several accompanying health problems or diseases. People become more and more susceptible to chronic diseases, physical disabilities and mental incapacities in their old age. The decline in the efficient functioning of the various organ systems of the body including the immune system renders the elderly particularly vulnerable to several diseases. As age advances, due to deteriorating physiological conditions, the body becomes more prone to illness. The illness of the elderly is multiple and chronic. Some of the health problems of the elderly can be attributed to social values also. The idea that old age is an age of ailments and physical problems is deeply rooted in the Indian mind, and many of the sufferings and physical troubles within curable limitations are accepted as natural and inevitable by the elderly.

Among the aged, the males seemed to be feeling that they had a better health condition even with sickness compared their female counterparts. As against this, about 13 to 17 per cent of the aged who were not even sick considered themselves as having a poor state of health. Rural aged seemed to be feeling that they had a better health condition even with sickness as compared to the urban aged. Ability to move is an important indicator of the physical condition of health of aged persons. It also indicates their dependence on others for movement and performing their daily routine. Regarding the proportion (number per 1000) of the aged persons who cannot move around and are confined to their home or who cannot move at all and are confined to bed.

Traditionally, the subjective well-being of the elderly has been ignored as the focus has been on the immediate effects of infectious and chronic diseases.

However, it is becoming increasingly clear that the mental health and well-being of the elderly population is an important aspect of growing older and requires urgent attention from researchers as well as policymakers.

Spectacles, walking sticks, dentures and hearing aids are available as aids to the elderly who have problems with their faculties. Spectacles are the most common form of disability aid used, followed by walking sticks. However, there appears to be a serious unmet need for disability aids, especially spectacles and hearing aids, which can be easily addressed by the right policies and programs.

One in every 10 elderly people in Tamil Nadu indulges in risky health behaviour; smoking, chewing tobacco or consuming alcohol. Of these, chewing tobacco is most prevalent the proportion that indulges in risky health behaviour is much higher in rural areas (17%) than in urban areas (9%) and much higher among men (18%) than among women (9%). The presence of acute and chronic morbidity or short and long-standing illness is an important aspect of the study of the health status of the elderly as morbidity increases with advancing age and both prevalence and incidence are likely to be high.

The most commonly cited illness was gastro-intestine related, followed by fever. Men in rural areas were more likely to approach a government health clinic, men in urban areas were more likely to approach private physicians. However, women in urban areas were more likely to approach a government health clinic than private physicians. The expenditure on treatment of acute morbidities is revealing. By far the highest level of expenditure is incurred in private hospitals. High levels of expenditure are incurred on treatment in urban areas as well, and by the elderly belonging to SC/ST social group. In Government hospitals, the major expenditure is on diagnostic tests, while in private hospitals the major expenditure is on consultations. This is one area where intervention can easily be made to reduce the cost of treatment in government hospitals.

Chronic Morbidities

Non-communicable diseases (NCDs) are being acknowledged as major contributors to the disease burden in India. With an increasing proportion of elderly in

the population, the burden of chronic diseases has been rising in India. Chronic ailments are illness suffered over the long term and the most common types of ailments reported by the elderly in Tamil Nadu are arthritis, hypertension, cataract, diabetes, asthma, and heart disease. Arthritis is the most commonly reported chronic ailment, and it affects more women than men and more elderly from rural areas than urban areas.

While the majority of the elderly who had hypertension, diabetes, asthma and heart disease sought treatment for their ailments, fewer of those who reported that they had arthritis or cataract did so. There were no differences between men and women in the seeking of treatment for various chronic ailments except for asthma where more women sought treatment than men and cataract where more men sought treatment than women. More elderly in urban areas sought treatment for heart disease than their counterparts in rural areas. The elderly were significantly more likely to seek treatment for heart disease from private hospitals than from government hospitals

Financial reasons were most commonly cited for not seeking treatment for hypertension; while a high proportion of the elderly did not consider ill health due to arthritis, cataract, diabetes, asthma and heart disease to be serious. The elderly spent significantly more on the treatment of heart disease and cataract from private hospitals compared to the expenditure in either government or private hospitals for the other common ailments. Most common sources of payment for treatment were self or children. To evaluate the health status of inmates, the SF-36 Questionnaire has been used in this study.

1.10.1 Health self-assessment - SF 36 Questionnaire

1	**In general, would you say your health is:**	
a)	Excellent	
b)	Very good	
c)	Good	
d)	Fair	
e)	Poor	
2	**Compared to one year ago, how would you rate your health in general now?**	
a)	Much better now than one year ago	
b)	Somewhat better now than one year ago	
c)	About the same	

d)	Somewhat worse now than one year ago		
e)	Much worse now than one year ago		

Does your health now limit you in activities? If so, how much?		**Yes, limited a lot**	**Yes, limited a little**	**No, not limited at all**
3	Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports			
4	Moderate activities, such as moving a table, pushing a vacuum cleaner or playing golf			
5	Lifting or carrying groceries			

Does your health now limit you in activities? If so, how much?		**Yes, limited a lot**	**Yes, limited a little**	**No, not limited at all**
6	Climbing several flights of stairs			
7	Climbing one flight of stairs			
8	Bending, kneeling or stooping			
9	Walking more than a mile			
10	Walking several blocks			
11	Walking one block			
12	Bathing or dressing yourself			

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your **physical health**?

		Yes	**No**
13	Cut down the amount of time you spent on work or other activities		
14	Accomplished less than you would like		
15	Were limited in the kind of work or other activities		
16	Had difficulty performing the work or other activities (for example, it took extra effort)		

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any **emotional problems** (such as feeling depressed or anxious)?

		Yes	**No**
17	Cut down the amount of time you spent on work or other activities		
18	Accomplished less than you would like		
19	Didn't do work or other activities as carefully as usual		

20 During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal **social activities** with family, friends, neighbours, or groups?

a)	Not at all	d)	Quite a bit
b)	Slightly	e)	Extremely
c)	Moderately		

21	**How much bodily pain have you had during the past 4 weeks?**		
a)	None	d)	Moderately
b)	Very mild	e)	Severe
c)	Mild	f)	Very severe

22	During the past 4 weeks, how much did pain interfere with **your normal work**?	
a)	Not at all	
b)	A little bit	
c)	Moderately	
d)	Quite a bit	
e)	Extremely	

These questions are about how you feel and how things have been with you **during the past 4 weeks**

		All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
23	Did you feel full of pep?						
24	Have you been a very nervous person?						
25	Have you felt so down in the dumps that nothing could cheer you up?						
26	Have you felt calm and peaceful?						
27	Did you have a lot of energy?						
28	Have you felt downhearted and blue?						
29	Did you feel worn out?						
30	Have you been a happy person?						
31	Did you feel tired?						

32	During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities?		
a)	All of the time	d)	A little of the time
b)	Most of the time	e)	None of the time
c)	Some of the time		

How true or false is each of the following statements for you?		Definitely True	Mostly True	Don't know	Mostly False	Definitely False
33	I seem to get sick a little easier than other people					
34	I am as healthy as anybody I know					
35	I expect my health to get worse					
36	My health is excellent					

1.11 Problems of ageing

If the problems of the aged are unattended and unsolved, it will affect social development. These problems are very different from other social problems. They differ from individual to individual based on the socio-cultural, economic and health factors. The problems faced by senior citizens are plenty especially those who are staying in old age homes face many problems.

Physical problems

General reduction of physical and mental abilities such as feeling less well than usual, difficulty in working, fatigue, greater need for rest and sleep, forgetfulness and loss of confidence, illness due to cold, cough, fever, headache, body pain, dental problems, weak eyesight and impaired hearing, and major illnesses such tuberculosis, paralysis, asthma, anaemia, diabetes, blood pressure, cardiac trouble, etc., (Kumar, 1995). Genetic factors, environment, sanitation and health hazards, malnutrition, poor nutrition, protein-calorie malnutrition are common in elderly persons in old age homes, Relative immobility and obesity are also important factors which affect normal health (Hasan, 1998).

Most of the aged need medical care and many of them are unable to consult the doctor even in the primary health centre because of their poor health or lack of locomotor ability. More than medical care, the aged needs moral and psychological care. They need a shoulder to lean on and a listener for their words. This task can be fulfilled by the old age homes (Vijayalakshmi, 2000).

Family problems

If the older person is economically dependent on the children, the problem is likely to become even worse (Prakash, 1999). The parents predominantly prefer to live with their children even when they have problems with them. Living in old age homes was the least preferred choice.

Psychological problems

Due to increasing specialization and mechanization, people are isolated and therefore the senior citizens are left alone. Because of their non-productive life, they feel bored which leads to psychological depression. Institutionalized elderly may experience the feeling of rejection at the time they join. They have complaints that family members do not pay enough attention, if spouses are living, they play a supportive role for each other, but if one spouse is dead, the living spouse feels very lonely and desperate. Misunderstanding with old age home inmates and staff members also create a big psychological problem (Papalia, 1992).

Economic problems

The economic status of the aged varies from individual to individual. They need more money for medical expenditure. Some elderly survive with their pension. Others are fully depending upon their children. Institutionalized elderly have less economic problems compared to non-institutionalized elderly. Because they get food, shelter, clothes, medical care and also social security from the old age home. A man's life is normally divided into five main stages namely infancy, childhood, adolescence, adulthood and old age. In each of these stages, an individual has to find himself in different situations and face different problems.

In old age, physical strength deteriorates, mental stability diminishes; money power becomes bleak coupled with negligence from the younger generation. According to an estimate, nearly 40% of senior citizens living with their families are reportedly facing abuse of one kind or another, but only 1 in 6 cases comes to light. Although the Government has given the assent to the Maintenance and Welfare of Parents and Senior Citizens Act which punishes children who abandon parents with a prison term of three months or a fine, the situation is grim for elderly people in India.

According to NGOs incidences of elderly couples being forced to sell their houses are very high. Some elderly people have also complained that in case of a property dispute they feel more helpless when their wives side with their children. Many of them suffer in silence as they fear humiliation or are too scared to speak up. According to them, a phenomenon called 'grand dumping' is becoming common in urban areas these days as children are being increasingly intolerant of their parents' health problems. After certain age health problems begin to crop up leading to losing control over one's body, even not recognizing own family owing to Alzheimer are common in old age. It is then children began to see their parents as a burden. It is these parents who at times wander out of their homes or are thrown out. Some dump their old parents or grandparents in old-age homes and don't even come to visit them anymore. Delhi has nearly 11 lakh senior citizens but there are only 4 governments' run homes for them and 31 by NGOs, private agencies and charitable trusts. The facilities are lacking in government-run homes.

Depression

Depression is a common condition in older people affecting about 17-30% of inmates of old age home over the age of 65 years. Depression is one of the most common mental disorders affecting 340 million people in the world today. The World Health Organization (WHO) has predicted that by 2030, depression will be the second biggest health problem world-wide and a leading cause of disability and death worldwide, second only to heart disease. On average, one in five people will experience depression at some point in their life.

The elderly population has increased, their problems are also increasing and depression has become a major problem. it is important to assess the burden of depression among the two groups to take suitable interventions at a particular group and help them to tackle their problem and increase their quality of life. Depression is among the most treatable of psychiatric illnesses. More than 80 per cent of those who seek treatment for major depression experience significant improvement and almost all individuals derive some benefit from medical care. Depression, if untreated, may lead to suicide. People with untreated severe depression have a suicide rate of about 15 per cent.

A research study stated that depression was found to be more in inmates of old age homes. Among the 50 cases in old age homes, 4 of them were having mild depression, 28 were having moderate depression and 18 were having severe depression. Among the 50 cases studied from the community, 34 were having mild depression, 14 were having moderate depression and 2 were having severe depression. On sex-wise analysis depression was found to be more among females. Occupation wise and age-wise analysis proved to be insignificant.

The prevalence of depression among inmates of old age homes especially in south India was moderately high (39.04%) among the elderly in the study population and it was observed that several important socio-demographic variables had shown a significant association with depression in the elderly. Studies have revealed that the prevalence rates for depression in the elderly, old age home samples of elderly in India vary from 6% to 50%. The prevalence of depression in South Asian populations in the West varies from1% to 42%. Investigator found that those aged who are severely depressed and who require an institutional treatment are more in old age homes (25.71%), followed by those living in the affluent areas (22.8%)and those living in the slums (11.4%). Studies reveal that the prevalence of cases of mental disorders needing institutional treatment is around 67 per 1000 population.

1.12 Old age homes

There has been a distinct change in the Indian family system for the past 50 years. Joint families are turning nuclear families. The status of the elderly has also changed in the present family system. In some cases elderly members of relatively rich families or aged persons who have nobody to look after takes shelter in old age homes. The elderly live in these homes merely in terms of existence to complete the last phase of their lives (Ghosh, 2006). It is known that social support should be seen as a last resource. Nevertheless, these institutions have to struggle to obtain quality services, which sometimes, are not achieved.

The genesis of old age homes

Each family has its problems, with a single child or two or many sons and daughters to look after parents. As they give priority to their own lives with a bright

future, many children face the embarrassment of taking care of their parents. Here comes the question of whether to stay back in the country to provide a comfortable life for parents in their advanced age or to migrate to other countries. Attracted by advanced technologies that provide opportunities to prosper in life and by materialistic benefits, many youngsters migrate to greener pastures, leaving behind parents to take care of themselves or with relatives. In the absence of either option, the choice is to leave the elders in OAHs under the care of others who manage the system. Thus OAHs was born to help chiefly the non-resident Indians (NRIs), to relieve them of the tension of leaving behind parents under the care of someone outside the family system. So, the OAHs were a concomitant of the emergence of the nuclear family system.

Having said that, it must be admitted that there are sons and daughters in some families who do not want to leave their aged parents and prefer to take care of them until their last breath, by opting to remain in the country with the satisfaction of whatever employment and other benefits they have commensurate with their education and qualifications. Thus, the mindset of children varies widely and parents have learnt to compromise with the given situation.

1.12.1 Life in old age homes

Just as in the case of systems in other sectors, OAHs have also become highly commercialized. There has been a virtual mushrooming of OAHs in recent years. It has become a lucrative business; NRIs are prepared to shell out huge deposits to admit their helpless parents in OAHs. The cost of providing accommodation, food, comforts and medical help is high.

The number of OAHs in the country reveals that there are different categories of them to cater to the needs of elders, depending on the payment capacity. While some OAHs seem to provide good facilities, others lack such comforts. It is not that all elders are taken care of well by the management. Some of them impose restrictions. The food served is reported to be of low quality and deficient in quantity in many of them. A recent newspaper report spoke of how a poor elder in an OAH was beaten for asking for more food. So also their bedrooms and toilets are often poorly maintained. Some of the managements do not utilize payments made to them by children in India and abroad, leaving the helpless parents in the lurch.

Such abuse and misuse of OAHs come to the limelight often, but seldom is an action taken to rectify the situation. There are some well-managed OAHs too, though they are very costly. Thus, most of the elders in OAHs are not very happy, confined as they are isolated. Unfortunately, children are unable to come on time when parents fall sick or even die in OAHs. But some elders feel comfortable in OAHs for the freedom and friendly atmosphere with other elders who keep them company, enjoying the time with TV, games and gossip. They show some detachment from family members and feel more secure in OAHs and avoid a restricted life with their children. The life of elders in the present age is full of problems, both for themselves and for the children. The fortunate few depart with satisfaction and peace of mind, while others leave with an unhappy state of mind. Meanwhile, the OAHs have come to be a part of our social system.

Several old age homes may not be in the best of conditions yet the demand for retirement options is on the rise. According to the executive director of International Longevity Centre India, Anjali Raje, seniors make up as much as 8% of the city's total population and the demand for old age homes is increasing. Raje added that there is a growing demand for such homes as more and more senior citizens are being left alone by their children out of choice or necessity. With the IT industry flourishing in the city, she said more youngsters are settling here, which will eventually lead to a larger elderly population in the years to come.

Growing old is a lonely business anywhere, but more so in Tamil Nadu than elsewhere in the country. The state has the highest number and proportion of elderly people living on their own, especially elderly women. Roughly one out of every 12 people aged over 60 in Tamil Nadu 7.5% to be precise lives all by him or her. Compare that with the national average of 4% or one in 25. For old women, the situation is even worse. More than one in every nine (11.5%) has no companionship or support at home against the national average of 5.5%. Women comprise more than three-quarters (78%) of the elderly people living all alone in the state. Of the four lakh elderly people living alone in the state, 3 lakh are women, the highest in the country. After Tamil Nadu, it is Andhra Pradesh that has the highest number and proportion of elderly men and women leading lonely lives. There are 3.8 lakh elderly people living alone in Andhra Pradesh, and of this nearly 3 lakh are women.

In fact, across all regions in the south, the average number of elderly women living alone for every 1,000 elderly men living alone is much higher than the all-India figure of 2,300. However, the proportion of homes with elderly people in Tamil Nadu is the same as the all-India average. In most states, there are more elderly women than men while in Tamil Nadu they are almost equal. When it comes to the overall sex ratio of the 60+ population, Tamil Nadu is lower than even the all-India average, way below states like Orissa, Gujarat and Madhya Pradesh. That is quite unlike the pattern of the other southern states, which have many more elderly women than men.

As per information available with Help Age India, there are 1279 Old Age Homes in India. Detailed information of 836 homes is available and for 443 homes only contact details are available. 543 homes provide free of cost services while 237 old age homes are on pay & stay basis. 161 homes have both free as well as pay & stay facilities. 214 old age homes accept medical/ constant care cases. 133 homes are exclusively for older women. Source: Directory of Old Age Homes in India 2009, published by Help Age India.

As per the Maintenance and Welfare of Parents and Senior Citizens Act, one old age home has been established in every district, but there is no mechanism to check how such facilities are functioning. On the one hand, there is a problem of the stigma attached to such homes, on the other, the living conditions leave a lot to be desired. At the same time, there is no one to monitor the functioning of such institutions, Raje explained (2016). Ram Gambhir, professor of Anthropology at Savitribai Phule Pune University (SPPU), said that the biggest problem with old age homes is the lack of registration and accountability. Old age homes are necessarily meant for the elderly living. The inmates in old age homes are those who are unable to stay with their families or are utterly poor. There are old age homes in almost all states in India

1.12.2 Old age homes in South India

The first old age home in India is supposed to have been started in the early eighteenth century. According to the statistics, 52 per cent of old age homes are located in south India (Kerala, Tamilnadu, Andhra Pradesh and Karnataka). As of 1995, Kerala state led with 102 old age homes, followed by Tamilnadu with 94 and Maharashtra with

65. In India the highest number of old age, homes are found in Kerala followed by Tamilnadu (Table 1.8).

Table1.8

State-wise distribution of old age homes in south India

State	Number of old age homes	
	1998	**2010**
Kerala	123	282
Tamilnadu	115	231
Andhra Pradesh	76	114
Karnataka	64	91
Total	378	718

Source: Directory of old age homes in India, Help age India, New Delhi 1998, 2010.

As per 2010 Directory of help age India, 231 old age homes were established in Tamilnadu. Among them, 147 old age homes were situated in and around Chennai. In Tamilnadu, the highest numbers of old age homes are in Chennai. Particularly, 130 old age homes are in Chennai (Help age India, May 2012).

As the joint families are regenerating into nuclear families, more and more elderly people are ending to live alone. Three out of every ten elderly people are living alone. Not only living alone, but many of them are also living in single independent homes without having any supporting help. Loneliness and insecurity are thus become their major concerns. Security is for most requirements for the elderly living. The survey indicates that 80% of elderly people feel insecure in their later living. Many of them feel insecure in life on retirement.80% of the elderly people would like to work after retirement to sustain their livelihoods. Changing the family value system, economic compulsions of the children, neglect and abuse has caused elders to fall through the net of family care. Homes for the Aged are ideal for elderly people who are alone, face health problems, depression and loneliness.

1.12.3 Types of old age homes

As like any other institutions, there are separate old age homes for males, females as well as mixed exist in India. Some of the old age homes are meant for only

aged persons. Some of the old age homes take only poor, aged and destitute. Some are aiming to help the sick and handicapped (Irudaya Rajan, 2000). Old age homes are of three types. They are (a) Free old age homes (b) Paid old age homes (c) Free-cum-Paid old age homes. There are seven sub-categories of old age homes in Tamilnadu. Some free homes run only for women, some for men and some for both men and women. However, in Chennai, there are no separate paid homes or free-cum-paid homes for men. In free homes, the inmates need not pay any fees. Generally, such homes are run by religious organizations belonging to Christian or Hindu organizations or secular trusts. Their chief motive is service. Normally the age of admission is 60 and above in free homes.

In some free homes once they get admitted they will be looked after till they breathe their last. In some free homes, a strict condition for admission is destitution. Hence, once they get admitted they cannot have any visitors but in some other homes destitution is not a condition and hence relatives are encouraged to visit them. Homes run by Christian organizations offer free accommodation and they get sufficient funds. So providing for the physical needs of the old is satisfactory. Some paid homes are run only for women and some for both men and women. The paid homes charge a monthly fee from the inmates and collect a refundable deposit. The deposit is charged so that on the death of the inmate the relatives may come, if not for anything else, at least for the sake of money. Suppose they do not turn up, the deposit is used to meet the funeral expenses.

Table 1.9 Types of old age homes

Types		Subcategories of old age homes
Free homes	1	Free homes for men & women
	2	Free homes for only women
	3	Free homes for only men
Paid homes	4	Paid homes for men & women
	5	Paid homes for only women
	6	Paid homes for only men
Free-cum-paid homes	7	Free-cum-paid homes for men & women
	8	Free-cum-paid homes for only women
	9	Free-cum-paid homes for only men

In paid homes, people are admitted even below the age of 60. Some homes insist that at the time of admission they must not be bed-ridden and be capable of self-care. Once they become bedridden they will be sent back. Some solely depend upon donations and mere subscription from members. So, living conditions in such homes are far from satisfactory level (Packiam, 2000).

In paid homes, some inmates do not stay a long time. They come to these homes on occasions of some unpleasantness and misunderstandings in the families. In a few months' time, things become normal and they do return. They maintain contacts with their families through phone calls and attend family functions. And they have a chance to shift from one old age home to others if they are not happy. If they are pensioners they pay the fees otherwise their family pay the fees. Reasons for coming to these old age homes vary from persons to persons (verbal abuse, beating, denial of food).

In some paid homes elderly are accommodated free of charge as well as on payment basis. Those who pay, they get extra facilities. Based on their payment they provide television, table fan, etc. Some old age homes provide a nutritional diet. Other homes provide what they have. Some homes are run without any financial support. They can only provide two meals a day. Some homes do not have their building. So they have to pay the rent. Also, many homes do not get any voluntary service by doctors and hence medical expenses of these homes are also very high. In these economic situations, these homes cannot afford to employ workers. In old age homes very few get old-age pensions of Rs.1000 per month and this amount goes to the management. In a few well-established homes a part of this money is given back to them as pocket money.

1.13 Supportive services for the aged

People in old age homes require supportive services like food security, economic security, emotional security, health security, companionship, recreational facilities, personal attender, etc. Some inmates give more importance to companionship. Food, security, companionship, recreational facilities are readily available in all institutions. Some old age homes provide sufficient health facilities. There are different types of medical facilities like first aid, treatment of minor ailments, referral services,

subsidized health care, timely health care, etc. Many institutions have first aid facilities. Timely health care is lacking in the majority of the institutions (Shoba, 2000).

The institutional living for the aged to a certain extent provided scope for sharing of the bottled up emotional securities. This is a tension-releasing mechanisms for the aged. Institutional care offers a place for recreation and a platform for overcoming, bouts of depression and a source for sharing feelings, thoughts and companionship. For many elderly who are in similar situations, the home becomes a place for supports, encouragement and a chance for finding friends.

a) **Religious beliefs**

One of the most important invisible sources of support for many inmates is religion. Several inmates admitted that their religious beliefs helped them adjust to home life. Many inmates were religious followers and they believed that religion would protect them and ensure them a wave of peace in later life. They practiced their religion by doing their daily tasks, chanting a sutra and reflecting on their conduct and participating in religious activities organized by their religious institutions. And the most common faith is the devotion to their family ancestors.

b) **Interpersonal relationship in old age homes**

Life in old age home revolves around three kinds of relationships. They are:

(a) Inmate-Inmate relationship

(b) Inmate-Staff relationship

(c) Inmate-Family/Friend relationship.

Interpersonal relationship is the most difficult issue in the process of adapting to institutional life. Whether or not an inmate was able to lead a happy home life largely depends on their capability in dealing with their relationship with others. Some people interacted actively to make friends while others refrain from interpersonal interaction to save trouble. If notions such as age, hierarchy, harmony, cooperation, consideration and endurances function well, the interpersonal relationship among inmates would be maintained smoothly and a supportive network would form. When these norms get violated, conflict arises. Supportive sources such as family and friends were also indispensable in institutional life. Individuals who received visits, calls and

presents from their families regularly or had many friends in the community were happy with their institutional life. Alienation from their families was one of the sources of some inmates' loneliness and dissatisfaction (Wu Yongmei, 2000).

1.14 Quality of Care

The services of the staff members directly influence inmates' quality of life. Workers in welfare institutions should have qualities such as thoughtfulness, a loving heart, keen judgments and cooperation. There are pre-requisites for good quality care. Staff members need to be more involved with the residents to know them, win their trust and to deal with their troubles. Whether or not a staff member is favoured by the residents depends largely on her personality, authority, coping strategy and fairness towards the residents.

Limitations of Institutional Care

The lack of privacy and choice in choosing a roommate is one of the main problems for inmates in old age home. Although most residents are considerate towards each other and restrain themselves to maintain a smooth relationship with their roommates and this peaceful surface is achieved at the expense of suppressing their own emotions. Deep friendships could be found between roommates, but latent tension as well as hostility also ubiquitously concealed under the surface harmony. When privacy is not ensured, conflict among roommates is unavoidable.

Accommodating mental patients together with normal elderly persons in old age homes caused another problem in institutional care. Prejudice towards mental illness and lack of professional skill among staff members to handle these patients to lead an easy life are the major problems. Some inmates with mental illness are alienated and ostracized. There are also problems such as lack of self-control and infringement of privacy. These problems could lead to lower satisfaction with institutional life on the part of the inmates.

1.15 Quality of life

Quality of life has been defined by the World Health Organization as an individuals' perception of their position in life in the context of the culture and value

system in which they live and about their goals, expectations, standards and concerns. It is a broad-ranging concept incorporating in a complex way the person's physical health, psychological state, level of independence, social relationships, personal belief and their relationship to salient features of the environment. This definition reflects the view that quality of life refers to a subjective evaluation which is embedded in a cultural, social and environmental context (WHO Quality of a life group, 1993).

The concept of quality of life is generally understood as satisfaction, happiness and fulfilment with various aspects of life. It expresses only through intangible facts such as feelings and emotions rather than tangible factors. However, certain tangible factors do contribute to a person's feelings about their quality of life. It is a multidimensional concept that helps measure satisfaction or dissatisfaction in areas of life. It is a dynamic concept, which changes across age, life stages, occupation, and social status and so on. Research Unit, University of Toronto (2005) quotes in their web site that 'Quality of life is an area of study that has attracted an ever-increasing amount of interest over the past two decades, particularly in the areas of health, rehabilitation, disabilities studies, and social services, but also in medicine, education and Others'. Quality of life is a multidimensional construct and includes material and non-material, objective and subjective, individual and collective aspects (Motel-Klingebiel, 2003).

1.16 Policy and Programs for the Welfare of Elderly Persons

Administrative setup

1. The Ministry of Social Justice and Empowerment is the nodal Ministry for the welfare of senior citizens.

2. The Ageing Division in the Social Defense Bureau of the Department of Social Justice and Empowerment develops and implements programs and policies for the senior citizens in close collaboration with State Governments, Non- Governmental Organizations and civil society. The programs for senior citizens aim at their welfare and maintenance, especially for indigent senior citizens, by supporting old age homes, daycare centers, mobile Medicare units, etc. These programs are implemented through providing support for capacity building of Government /Non-Governmental

Organizations (NGOs) /Panchayat Raj Institutions (PRIS) /local bodies and the community at large.

1.16.1 Integrated program for older persons (IPOP)

1. The Ministry of Social Justice and Empowerment is implementing a Central Sector Scheme of Integrated Program for Older Persons (IPOP) since 1992 intending to improve the quality of life of senior citizens by providing basic amenities like shelter, food, medical care and entertainment opportunities etc. through providing support for capacity building of Government/ Non-Governmental Organizations/Panchayat Raj Institutions/ local bodies etc.

2. The Scheme was revised with effect from 01.04.2008 and 01.04.2015. Besides revising cost norms of financial assistance for existing projects, several innovative projects were added as being eligible for assistance under the Scheme during the 2008 revision. The following projects are being assisted under the IPOP Scheme:

i. Maintenance of Old Age Homes;
ii. Maintenance of Respite Care Homes;
iii. Running of Multi-Service Centers for Older Persons;
iv. Mobile Medicare Unit;
v. Day Care Centre for Care of Older Person with Dementia;
vi. Multi-Facility Care Centre for Older Widows;
vii. Physiotherapy Clinics;
viii. Regional Resource and Training Centers;
ix. Helplines and Counseling for Older Persons;
x. Program for Sensitization Schools/College Student;
xi. Awareness Projects for Older Persons;
xii. Volunteers Bureau for Older Persons;
xiii. Formation of Vridha Sanghas/Senior Citizen Associations/SHGs;
xiv. Any other activity, which is considered suitable to meet the objectives.

1.16.2 The national policy on older persons (NPOP)

1. The National Policy on Older Persons (NPOP) was announced in January 1999 to reaffirm the commitment of the state to ensure the well-being of the older

persons. The policy envisages state support to ensure financial and food security, health care, shelter and other needs of older persons, equitable share in the development, protection against abuse and exploitation, and availability of services to improve the quality of their lives.

2. Keeping in view the changing demography of the senior citizens in the country over the last decade, the Ministry of Social Justice and Empowerment constituted a committee to (i) assess the present status of various issues concerning senior citizens, in general, and implementation of NPOP, 1999, in particular, and (ii) draft a new NPOP keeping in view the emerging trends in demographic, socio-economic, technological and other relevant fields.

1.16.3 International day for older persons (IDOP) and National awards: Vayoshreshtha Samman

1. The Ministry of Social Justice and Empowerment observes the International Day for Older Persons (IDOP) on 1st October every year in a benefiting manner by organizing a series of events and programs dedicated to the senior citizens. The day is dedicated to acknowledge the contribution of senior citizens to the society and to sensitize the public at large about their problems and needs and to make our society more elderly-friendly.

2. In order to recognize the efforts made by eminent senior citizens and Institutions involved in rendering distinguished services for the cause of elderly persons, especially indigent senior citizens, the Ministry of Social Justice and Empowerment (Department of Social Justice and Empowerment) has prepared a new scheme of national awards for senior citizens to showcase the Government's concern for senior citizens and its commitment towards senior citizens to strengthen their legitimate place in the society. The Scheme of National Awards for senior citizens has been notified in the Gazette of India on 22.01.2013 and was given for the first time during 2013.

3. Applications/nominations for National Award 2015 were invited through advertisements in National Dailies. The last date for inviting applications had been 15th May 2015 which was later extended till 31st May 2015. A function was organized at the Vigyan Bhawan, New Delhi wherein National Awards were conferred

on eminent senior citizens and Institutions, from any part of the country, in recognition for their contribution towards the cause of the elderly on 1st October 2015. President of India, Shri. Pranab Mukherjee gave away the National Awards. The Award in each category shall carry a Citation, a Memento and also Cash Award in some of the categories as decided from time to time.

4. In collaboration with a reputed NGO, this Ministry of Social Justice and Empowerment organized an Intergenerational Walkathon at the India Gate Lawns, Rajpath, New Delhi on the morning of 1st October 2015.

1.16.4 The Maintenance and Welfare of parents and senior citizens act, 2007

1. The Maintenance and Welfare of Parents and Senior Citizens Act, 2007 was enacted in December 2007, inter alia, to ensure need-based maintenance for parents and senior citizens and their welfare. The Act shall come into force in a State on such date as the State Government may, by notification in the Official Gazette, appoint. So far, all the States and UTs have notified the Act. The Act does not extend to the state of Jammu and Kashmir. Himachal Pradesh has its Act for the welfare of Parents and Senior Citizens.

2. The Act provides for:

i. Maintenance of Parents/ senior citizens by children/ relatives made obligatory and justiciable through Tribunals

ii. Revocation of transfer of property by senior citizens in case of negligence by relatives

iii. Penal provision for the abandonment of senior citizens

iv. Establishment of Old Age Homes for Indigent Senior Citizens

v. Protection of life and property of senior citizens

vi. Adequate medical facilities for Senior Citizens

3. Consequent upon notifying the Act, State Governments/UT Administration are required to take the following necessary measures/ steps for effective implementation of the Act:

i. Frame Rules u/s 32;

ii. Appoint Maintenance Officers u/s 18 (1);

iii. Constitute Maintenance Tribunals u/s 7 (1); and

iv. Constitute Appellate Tribunals u/s 15 (1).

1.16.5 National council for older persons (NCOP)/ National council of senior citizens (NCSrC)

1. In pursuance of the National Policy for Older Persons (NPOP), a National Council for Older Persons (NCOP) was constituted in 1999 under the Chairpersonship of the Minister for Social Justice and Empowerment to oversee implementation of the Policy. The NCOP is the highest body to advise the Government in the formulation and implementation of policy and programs for the aged.

2. To have a definite structure as well as regional balancing, National Council for Older Persons (NCOP) has been reconstituted and renamed as National Council for Senior Citizens (NCSrC) vide a resolution dated 17-2-2012 which was published in the Gazette of India on 22-2-2012. The NCSrC will advise Central and State Governments on the entire gamut of issues related to the welfare of senior citizens and enhancement of their quality of life. The NCSrc will meet at least twice a year.

1.16.6 Benefits extended by other central ministries for the welfare of senior citizens

1. The Ministry of Rural Development is implementing the Indira Gandhi National Old Age Pension Scheme (IGNOAPS) under which Central assistance is given towards pension Rs. 200/- per month to persons above 60 years and Rs. 500/- per month to persons above 80 years belonging to a household below the poverty line, which is meant to be supplemented by at least an equal contribution by the States.

2. The Ministry of Health and Family Welfare provides the following facilities for senior citizens of Separate queues for older persons in government hospitals.

a) Geriatric clinic in several government hospitals.
b) The Ministry implemented the National Program for the Health Care for the elderly (NPHCE) from the year 2010-11. The objectives are to;
    1) Provide preventive, curative and rehabilitative services to the elderly persons at various level of health care delivery system of the country
    2) Strengthen referral system
    3) Develop specialized manpower and

4) Promote research in the field of diseases related to old age.

Major Components

1) To establish a geriatric department in all the existing 8 Regional Geriatrics Centers
2) Strengthening healthcare facilities for the elderly at various levels of 100 identified districts in 21 States of the country.
3) Regional Institutions to provide technical support to geriatric units at district hospitals whereas district hospitals will supervise and coordinate the activities down below at CHC, PHC and sub-centres.

3. Ministry of finance- Health Insurance: Insurance Regulatory Development Authority (IRDA) vides letter dated 25.5.2009 issued instructions on health insurance for senior citizens to CEOs of all General Health Insurance Companies which, inter-alia includes:

1) Allowing entry into the health insurance scheme till 65 years of age.
2) Transparency in the premium charged
3) Reasons to be recorded for denial of any proposals etc. on all health insurance products catering to the needs of senior citizens. Likewise, the insurance companies cannot deny renewability without specific reasons.

Tax Benefits: The Ministry of finance provides the following facilities for senior citizens for the Assessment Year 2016-17:

1) Income tax exemption for Senior Citizens of 60 years and above up to Rs. 3.0 lakh per annum.
2) Income tax exemption for Senior Citizens of 80 years and above up to Rs. 5.0 lakh per annum.
3) Deduction of Rs 30,000 under Section 80D is allowed to an individual who pays the medical insurance premium for his/ her parent or parents, who is a senior citizen.
4) An individual is eligible for a deduction of the amount spent or Rs 60,000, whichever is less for medical treatment of a dependent senior citizen suffering from specified diseases. For senior citizens of 80 years and above the limit is Rs 80,000.

4. Ministry of home affairs - Protection of Life and Property: the Maintenance and Welfare of Parents and Senior Citizens Act, 2007 provides for the protection of life and property of senior citizens. State Governments are required to prescribe a comprehensive Action Plan for protecting life and property of senior citizens. The Ministry of Home Affairs, Government of India has also issued detailed advisories dated 27.3.2008 and 30.08.2013 to all the State Government/UTs, who are primarily responsible for prevention, detection, registration, investigation and prosecution of crime including crime against senior citizens.

The Ministry of Home Affairs in its advisories has advised the States/UTs to take immediate measures to ensure safety and security and for the elimination of all forms of neglect, abuse and violence against old persons through initiatives such as identification of senior citizens; sensitization of police personnel regarding safety, the security of older persons; regular visit of the beat staff; setting up of toll-free senior citizens helplines; setting up of senior citizen security cell; verification of domestic help, drivers, etc.

5. Ministry of railways - Concession in Rail Fares: The Ministry of Railways provides the following facilities to senior citizens:

1) Separate ticket counters for senior citizens of age 60 years and above at various Passenger Reservation System (PRS) centres if the average demand per shift is more than 120 tickets;
2) Provision of a lower berth to male passengers of 60 years and above and female passengers of 45 years and above.
3) 40% and 50% concession in basic rail fare for male (60 years) and female (58 years) senior citizen respectively.
4) Wheelchairs at stations for old age passengers.

6. Ministry of civil aviation - The National Carrier, Air India under the Ministry of Civil Aviation provides airfare concession in up to 50% of the basic fare of normal economy class for senior citizens who have completed 63 years of age on the date of commencement of the journey and on the production of proof of age (Photo-ID) and nationality (Ministry of Social Justice and Empowerment and other Ministries as on 1 February 2016).

Rights of the Elderly

- Parents cannot be evicted from a house without due process of law if they have been staying there from before. Three enactments can be applied.
- Under section 125 of the Cr PC, a magistrate can order a child to maintain his old parents under the Maintenance of Parents Act.
- The Hindu Adoptions and Maintenance Act say an aged parent can demand maintenance from children in the same way that a wife can demand it from her husband.
- The Domestic Violence Act to provides parents with the right to seek relief from any kind of abuse.

A National Policy on older persons was announced in January 1999 which identified some areas of intervention-financial security, healthcare and nutrition, shelter, education, welfare, protection of life and property for the wellbeing of older persons in the country. A National Council for Older Persons (NCOP) was constituted by the Ministry of Social Justice and Empowerment to operationalize the National Policy on older persons.

1.17 Theoretical framework of the study

Social gerontology began to develop as a discipline of study during the 18th century. It became the task of this new discipline to study and provide scientific explanations for the disturbing phenomena related to ageing. As a result of the work done by social gerontologists from that time until the present, some different and often conflicting theories of ageing emerged as explanations of the social and psychological losses that tended to accompany old age. These theories are used to discover the causes of certain social phenomena such as the disengagement patterns of elderly people.

Social gerontologists approach the study of ageing on one of two basic levels of analysis-the micro level or the macro level; (i) at the micro-level of analysis, the concern is with changes in a biological system or the psychological aspects, as well as the interaction between these two microsystems; (ii) the macro-level analysis is concerned with the impact of social structure, processes and problems on the ageing population or an individual (Riley, 1980).

1.17.1 Micro level theories of ageing

(a) Role Theory

The two basic concepts of 'Status' and 'Role' associated with role theory was introduced by Sociologist Linton (1936). Social status refers to a socially defined position within a given social structure that is separate from but related to other positions. Status can be achieved by an individual through personal choice or by competition and use of training and abilities. Examples of acquired or achieved status positions include lawyer, father, employer, or spouse. Status positions may also be ascribed at birth (male or female, black or white, or caste), or they may be acquired at some later stage in life (widow or retiree). Associated with each status position, there is a social role. This represents a social definition of the behavioural patterns, rights and responsibilities expected from those occupying a specific status position.

The process of ageing involves major role transitions from being a provider to a receiver or acquired roles such as widowhood, role changes arising of retirement, death of friends or loss of independence (Marshall, 1980). The role changes in old age are viewed as physiological, psychological and social loss; as a period when new social relationships and roles typical of later life are adopted. Ageing throughout the life cycle is viewed as a process that involves both gains and losses in a variety of interrelated roles. For some elderly people, the transition may be stressful and coping may be difficult; for others, it will be uneventful and successful (Larson, 1978).

(b) Quality of life theory

The concept of quality of life was established in the 1960s. It arises from the acknowledgement that to have a fulfilling life, there are different domains in a person's life which need to be realized. Maslow presented a hierarchy of needs which he argued were important to any individual to realize a happy and fulfilled life. The lowest and most basic needs are as follows. These basic needs according to Ventegodt, Merrick, and Anderson, (2003) were divided into four groups. The first set of needs was physiological needs and these included aspects such as food, clothes and sleep. The second group focused on the need to have peace of mind. One of the main aspects of human life which fall under this group was an individual being able to access decent

and safe accommodation. Thirdly, Maslow wrote about human beings need for love and here he brought about the aspect that everyone wanted to belong somewhere and to be cared for by someone. Fourthly, every individual needed to be respected. All these facets of Maslow's theory on quality of life are important in this study.

Wilhelm son (2005) support the view by arguing that there are many dimensions to quality of life such as physical functioning, cognitive functioning, health perceptions, economic status, and recreation. Wilhelm son and colleagues (2005) argue that 'if social and health services are to assist people to improve their quality of life; they need to know what aspect of their lives people themselves consider to be important'. All these are generally perceived to be pivotal in ensuring that individuals have a certain basic level of fulfilment. One key problem, which has been identified with a quality of life approach, is that there has not been a standardized definition of what quality of life is? This reflected in the approaches described above.

Wilhelm son and colleagues (2005) point of view suggest any intervention or assistance improve the quality of life to be effective should take into account what people consider important. This means social, health or welfare policies or programs should be aligned to aspects important for people being helped or supported. This brings in an important aspect of the difference between what the elderly people themselves think is important and what outsiders, which include the policymakers, think is important. This point is particularly important in studying the elderly, relatives supporting them and policies designed for them because one of the main underlying factors is the need to improve elders' quality of life.

(c) Reference group Theory

According to reference group theory, individuals identify with groups and use them as a frame of reference for their behaviour, attitudes, values, beliefs and feelings. Individuals normally adopt the standards of a group they perceive as positive and reject those of a group perceived as negative. As we age, we selectively utilize a variety of reference groups that guide our behaviour and either enhance or destroy our self-image. For example, Romeis (1971) hypothesized that well-adjusted aged individuals have high-quality interaction with their reference groups, receive positive feedback about themselves (a positive self-image) from their reference groups and have

values and norms that agree with those of the reference groups. Reference group theory analyzes the process whereby changes in age identity occur in the middle and later years of life.

(d) Social Learning Theory

Socialization is a lifelong process that enables an individual to participate in society by learning appropriate symbols for communication and by learning particular roles that will assist in developing a self-image or identity. As we age, the socialization process tends to be concerned with learning more specific roles and behaviours and tends to be more voluntary and interactive than in the earlier years (Mortimer and Simmons, 1978).

Furthermore, there seem to be three basic differences between socialization processes in earlier and later life. These include (1) a shift in emphasis from values and motives to a concern with overt behaviour; (2) a synthesis or revision of old knowledge rather than the acquisition of new material; and (3) an emphasis on learning specific role skills rather than on learning general behavioural traits. The social structure in which an individual lives influences socialization outcome. Differences in social structure can lead to different socialization outcomes. For example, an elderly widow who is forced to give up her home will be socialized quite differently for her future roles depending on whether she moves in with a child, enters a senior-citizen apartment, or becomes institutionalized in a home for the aged.

(e) Social Exchange Theory

The social exchange perspective is useful in explaining continuing patterns of interaction among individuals in accounting for age-specific allocation of roles and resources in social groups and in explaining the acquisition of power and independence by some individuals. A basic assumption of this theory is that individuals search for social situations in which valued outcomes are possible and in which their social, emotional and psychological needs can be met (Maddox and Wiley, 1976).

Sussman, the strongest proponent of this theory within gerontology, explains ageing behaviour as a process of social exchange. He suggests that the

decreased interaction noted in the later years is the result not of an inevitable process of disengagement, but a series of exchange relationships across the life cycle. As a result of these exchange relationships, relative social power diminishes as one age. Similarly, when individuals are perceived to be no longer able to care for them, they are institutionalized and cared for as repayment for past debts (Sussman, 1976).

(f) Activity Theory

Activity theory was the first theory in North America, an attempt to provide a description of and a prescription for, successful or ideal ageing in the later years of life. The idea of slowing down but keeping active in orders to adjust successfully to ageing was first suggested by Havighurst and Albrecht (1953). Later, Burgess (1960) suggested that old age should not be viewed as a 'Role less role' but that individuals should replace lost roles or social activities with new ones. This theory argued that individual adaptation involved continuing an active lifestyle of social interaction to maintain the self-concept and hence a sense of well-being or life satisfaction. The maintenance of this active lifestyle involved replacing lost roles, by either re-engaging in earlier roles or engaging in new roles.

A high degree of social activity and role involvement is positively related to life satisfaction in the later years of life. In short, the pattern that constitutes 'successful' ageing for a given individual is likely to be closely related to his or her personality. Self-concept, health, economic resources, and previous lifestyle, and whether he or she lives in an age-homogeneous or age-heterogeneous environment. The greater opportunity provided by an age-homogeneous environment may facilitate an adaptation process wherein high activity is necessary for high levels of satisfaction (Longino and Kart, 1982).

(g) Disengagement theory

Disengagement theory derives from both the departmental and the functionalist perspectives. Old age is viewed as different from middle age and change and adaptation in the later years are seen as functionally necessary both for the individual and the society (Shanas, 1968). Disengagement results in decreased interaction between an individual and others in society and is hypothesized to be a

universal process that is satisfying to both the individual and society. Disengagement is seen as a process wherein individuals, supported by societal norms and customs, voluntarily and gradually withdraw from social roles and decrease their social interaction. As a result, the individual is thought to experience a high level of satisfaction, wellbeing or morale in the later years of life. Hoch child (1975) hypothesizes that older men who have access to work and a history of valuing work highly will demonstrate a higher level of social and normative engagement in their work than in their family or leisure.

Furthermore, engagement is seen to be of two types: 'social' engagement, which refers to interaction with others at work, in the family, and leisure pursuits, and 'normative' engagement, which refers to the emotional importance and meaning attached to interaction. The social and normative engagement patterns adopted during middle age generally remain part of one's lifestyle in the later years.

(h) Continuity Theory

Continuity theory argues that as an individual's age, they strive to maintain continuity in their lifestyle (Williams and Wirths, 1965). According to the theory (Atchley, 1971), individuals adapt most successfully to ageing if they maintain a lifestyle similar to that developed in the early and middle years. In short, continuity theory suggests that the pattern of adjustment to ageing and whether it is successful or not for the individual is highly related to maintaining consistency in the established lifestyle. As a result, planning for the later years should involve knowledge of and adherence to a lifestyle established by the middle years. This is especially important concerning establishing a variety of meaningful and satisfying leisure activities in the middle years that can be pursued in the later years.

Covey (1981) notes that whereas most conceptualizations of continuity in lifestyle can only occur where there is compatible interaction between individual characteristics and the social structure. For example, social structural factors such as mandatory retirement lead to discontinuity in the occupational role. Covey concludes that structural constraints can be overcome, and continuity can be maintained when the individual has a high level of personal resources (wealth, power, health) that can be used to prevent or delay the impact of social structural forces that require role exit.

1.17.2 Macro level theories of ageing

The theories at macro level may further be categorized as Marxist theories including Conflict theory and Political Economy of ageing and Non-Marxist theories which include Age Stratification theory, Sub-culture theory and Modernization theory. Following is an attempt to explain 'Ageing' regarding these theories.

(a) Age stratification Theory

Most of the micro-level theories of social gerontologists focus on how the individual adjusts to being old; the theory of age stratification is concerned with an ageing relative to all stages in the life cycle. Thus the elderly are studied not in isolation, but to other age strata. This theory focuses on how the structure of a society affects the ageing individual and on differences between age strata rather than on conflict between them (Marshall, 1981).

At the societal level of analysis, the theory of age stratification argues that the population is divided into age strata because of cohort flow, that is fertility, migration and mortality determine the size and composition of each stratum (Waring, 1975). This theory which first appeared in the early 1970s was widely accepted as a viable explanation of changing behaviour and status across the life cycle, even though few research studies explicitly tested the theory. Most of the elderly seem to accept their devalued status and subordinate position in the age stratification system.

Age stratification models are flexible. As per the age stratification theory, socialization is a lifelong process as people move through a sequence of roles as they age. Age stratification model suggests that the link between age and a social individual will play in society, maybe either formal or informal (Formal, e.g., age of marriage, voting right, etc., and Informal, which may originate in tradition, factual regularity or negotiation, e.g., age of admission of a child to a school, etc.). An age cohort can be seen as a particular generation with other living generations and one that brings its attitudes, beliefs and values to bear on situations held in common (Cocker ham, 1991).

(b) Modernization Theory

Modernization theory seeks to explain ageing phenomena from a structural perspective rather than from the perspective of the individual. The theory was first described in detail by Cowgill and Holmes (1972) in a cross-cultural study that analysed the status of the aged in fourteen different societies. The major hypothesis of this theory was that the role and status of the aged vary inversely according to the degree of modernization in a society. As social change occurs and societies become more modernized older people lose functional roles, become devalued and subsequently lose status and security.

Maxwell and Silverman (1980) suggested that the elderly lose control of information with modernization and that this loss of control subsequently results in a loss of authority and power within the society. In agrarian economies the elderly controlled the ownership of land and thereby enjoyed a favourable exchange rate, In contrast, in modern societies, the elderly have less esteem, prestige and status than the elderly in more primitive societies.

(c) Environmental Theory

In an environmental theory of ageing, the concern is with the impact of the social or physical environment on the individual. This perspective represents a direct attempt to account for the interaction between the personal systems, the social system and the environmental system. Environmental factors impinge on the individual in two major ways throughout the life cycle. First, they may influence how an individual passes through the life course and how long he or she lives; second, they influence the development and expression of the characteristics of individuals and cohorts as they age.

The major thrust in examining the relationship between the ageing individual and the environment resulted from a growing interest in ageing in the late 1960s on the part of human ecologists. They sought to integrate knowledge from a variety of disciplines, relating man to his resources, his social and cultural patterns, and his social and physical environment. The theories have focused on explaining how the interaction of personal and environmental characteristics influences the coping and

interacting behaviour of the individual in old and new environments (Lawton and Rich, 1968, Bruhn, 1971).

(d) Sub-Culture of ageing theory

In the process of bringing elderly people throughout the state of Minnesota together to study senior citizen activity centres experimentally, Rose observed that those people began to interact more with each other than with others in their community (Rose, 1963). Based on that observation he predicted that, as the numbers of the elderly continue to grow, increasing numbers of them would come together in groups for two basic reasons: (i) the positive affinity they might feel for each other based on their common interests and (ii) the rejection they experience by younger age groups. Thus, they would inevitably interact more with each other than with others and a subculture of ageing would emerge.

Rose did not predict that all elderly people would become part of such a subculture because of such counter influences as continued affiliation with families, continued employment, and the tendency to actively resist being identified as old. Those who would be most apt to become participants in the subculture would be 'those in retirement communities, in rural communities from which young people are rapidly emigrating, and in the central parts of big cities' (Rose, 1965). Some analysts have argued that a subculture of ageing has not developed as Rose predicted (Rosow, 1974; Baum and Baum, 1980). Nevertheless, it is obvious that increasing numbers of exclusively age-related groups and communities are forming and that increasing numbers of the elderly do indeed interact more with each other in those groups than with others.

The above analysis of the micro-level and macro-level theories makes the elements of individual perception and activities; the social treatment to the aged in terms of attitude reflected through policies, provisions and practices; and the interaction between the two (individual and social environment). Just for the sake of understanding the process of ageing, these theories have been discussed. But satisfactory ageing is a result of various micro and macro-level factors in interaction with each other. And human being can change their environments. Attempts are required to be made at

micro-level (individual) and macro (environmental) level to make ageing a satisfactory phenomenon.

The present study aims at developing sociological perspectives on ageing. The study focuses mainly at the individual level, keeping the interactions and environmental level at the secondary level, to deal with the problem of the aged. So, it was thought best to apply micro-level theories in the present study. Thus, the present study attempts to test the quality of life theory, activity theory, and disengagement theory.

The quality of life theory explains the basic needs of the individuals. The basic needs are divided into four groups. They are physiological, psychological, social and environmental. These four groups of basic needs are needed to be fulfilled. The activity theory maintains that the aged who are active will be more satisfied than the less active elderly. And to be happy in old age, individuals need to be active. The disengagement theory is beneficial both for the individual and society. The above mentioned three main theories are used in this study. So the present study tries to find out the applicability and desirability of these three theories. The study also examines the association that exists between the degree of activeness and social interaction of the aged on the one hand and the level of their adjustment on the other.

1.18 Chapterization

The entire research is organized into ten chapters as given hereunder.

CHAPTER I: This chapter deals with **Introduction,** demographic profile of elderly and problems of ageing. It also emphasizes the types of old age homes, life satisfaction, living environment, social and economic support services, health status, quality of life, interpersonal relationships of the elderly people and theoretical framework of the study.

CHAPTER II: In this chapter, the **Review of literature** related to the Old age homes are presented. Mainly reviews were collected based on inmates' life satisfaction, living environment, social support, economic support and health status.

CHAPTER III: This chapter deals with the **Research methodology** of the study which includes an area of the study, sample selection, interview schedule and significance of the study.

CHAPTER IV: This chapter describes the **Profile of old age homes** in Chennai, Kancheepuram, Vellore, and Thiruvallur Districts.

CHAPTER V: This chapter deals with the **Socio-economic background** of the inmates in old age homes.

CHAPTER VI: This chapter brings out the **Life satisfaction** of the inmates in old age homes through the analysis of empirical data and interpretation.

CHAPTER VII: This chapter highlights the **Living environment** of inmates. It also describes the environmental conditions of elderly people in old age homes.

CHAPTER VIII: This chapter deals with **Social and Economic Support** of the inmates in old age homes and describes the Government policies, Schemes and Acts related to socio-economic factors, mainly for the elderly people.

CHAPTER IX: This chapter brings out the **Health status** of elderly people in old age homes through various standardized scales for the elderly people.

CHAPTER X: This chapter summarizes the **Findings** of the present study along with the major conclusion and recommendations.

CHAPTER II

Review of literature

2.1 Introduction

In this chapter, an attempt has been made to review the studies related to elderly people in old age homes. Review of literature provides an opportunity to understand the methods and approaches employed in the earlier studies. It provides a conceptual and theoretical context in which the topic for research can be suited.

In this study, the researcher has reviewed Indian and foreign studies that have specifically dealt with the 'Elderly people in old age homes'. The reviews have been classified on chronological order. Past two decades (21st century) reviews have been referred for the study. The review of literature has been collected on the basis of the following themes;

a) Studies related to Socio-economic condition of inmates
b) Studies related to Life satisfaction of inmates
c) Studies related to the Living environment of inmates
d) Studies related to Social support of inmates
e) Studies related to Economic support of inmates
f) Studies related to the Health status of inmates

Each section represents a category of literature that has been studied. Each of the categories plays an important role in addressing some of the fundamental issues relating to literature reviews as stated below. They have concluded that loneliness is a major reason for elderly seeking residence in old age homes. Admission criteria need to be friendly for uneducated elderly from lower socio-economic strata. Evidence-based, comprehensive health assessment module needs to be incorporated into the admission protocol to identify and predict potential acute health events. In dormitory-style accommodation, a minimum area of 120 sq. ft. per resident is essential. In independent room based accommodation, a minimum area of 200-250 sq. ft. should be planned per resident. Standard facilities for the disabled, facilities of library, common room, recreation room are needed for a decent quality of life.

2.2 Literature reviews

Laila et al (2020) explored the experiences of the older adults who were brought to live in shelter homes in Karachi, Pakistan. The aim of this study was to explore the experiences of the elderly people and to identify the reason which compelled them to reside in these shelter homes. A qualitative methodology, with a descriptive exploratory design, was adopted for the study. A purposive sample of 14 elderly males and females were selected from two different shelter homes in Karachi, Pakistan. The analysis discovered that the elderly were experiencing a lack of physical, psychological, emotional, and financial support from their family and children. It also indicated that migration of children for better career and employment opportunities, the entrance of women into the workforce, and insensitive behaviour of children, left the senior citizens neglected and helpless. The findings also uncovered the challenges of unemployment and family disputes that the elderly had to face made them dependent, distressed, helpless, and lonely resulting in both their apparently willing and forceful decision to reside in shelter homes.

Mariana et al (2020) analysed how the institutionalization influenced elderly's quality of life in Brazil. For qualitative synthesis, data were extracted and risk of bias was evaluated through a validated guideline. Meta-analysis was based on Mean Difference (MD) and Standard Mean Difference (SMD) calculation ($p \leq 0.05$). The evidence was quality-tested using Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach. The initial search identified 3841 articles. Out of 16 articles, 14 evaluated the Health-Related Quality of Life, using Leipad (n=2), WHOQOL-BREF and/or OLD (n=8), SF-36 or RAND-36 (n=4) questionnaires, and two assessed the Oral Health-related Quality of Life, through GOHAI questionnaire. Differences on elderly's QOL were detected through WHOQOL-BREF, WHOQOL-OLD and SF-36/RAND-36. All studies had a very low or low certainty of evidence, since the study design influenced evidence classification, and showed high heterogeneity. Although the institutionalization influences negatively the elderly's QOL, further well-designed studies are needed to confirm this evidence.

Sahaya Sona and Indumathi (2020) assessed and compared the quality of life of elderly living in old age homes and community in Kancheepuram district. QOL of elderly was assessed using WHO QOL - brief questionnaire after taking informed

consent from the participants. Data was analyzed using SPSS 23. A total of 106 elders from each group old age home and family setup were the study participants. Quality of life was good (72.5%) in family and in OAHs it was only 56.2%. The main reason for residing in OAHs was no family, lack of care takers. All the four domains were found to be highly statistically significant. From this study it was concluded that quality of life in family setup is better than OAHs, psychologically many people were depressed as they live separately from their family and relatives, friends and the community they lived.

Yoshiaki et al (2020) investigated Supplied Food Consistency and Oral Functions of Institutionalized Elderly. The Japanese national insurance system newly introduced the concept of management of oral function according to the life stage. For the application of management of oral functions of the elderly, seven kinds of examination is a must for the diagnosis: xerostomia, oral hygiene status, maximum occlusal pressure, tongue and labium function, tongue pressure, chewing ability and swallowing function. They analysed the relationship between oral functions and supplied food consistency of sixty-nine institutionalized elderly. There were 13 men and 56 women, and their mean age was 86.23±7.02. Oral functions were measured and evaluated according to the Japanese insurance system. Data were analysed by item response theory analysis, ROC analysis, and decision analysis. By the item response theory analysis, tongue pressure and swallowing functions had high discrimination ability. The subjects who had a malfunction of the tongue and labium all had processed food. The subjects with difficulty in swallowing, even without malfunction of the tongue and labium, all had processed food. Supplied food consistency may depend on the oral functions. However, as an oral function has some dimension, a systematize valuation systemic necessary to decide the supplied food consistency.

Aliya Mohamad et al (2019) explored perceptions and use of Gero technology: Implications for ageing in place. The study was conducted in Oregon. Research demonstrates that multidimensional factors are related to the use of new technology by older adults. The aim of this paper is the generation of a conceptual model that incorporates gerotechnology as a compensatory mechanism in the person-environment interaction to facilitate ageing in place. Four themes were discussed; they are safety, social interaction, use of technology and support. Most participants seemed to have a fear of falling and were concerned about how they could get help when they

fall. The respondents prefer professionals to watch their movements using monitoring technology, rather than burdening their family members. Receiving support is very important to the participants, especially when they fall. They believe that technology is useful and helpful for them and would allow them to live safely and independently.

Anand and Sethi (2019) aimed to explore the relationship between loneliness and depression among the elderly staying in the old age homes of Dehradun. The sample comprised of sixty elderly, aged 60-90 years who were living in old age homes of Dehradun. The tools used for this purpose were the Beck Depression Inventory and the UCLA Loneliness Scale. In the present study, depression and loneliness were found significantly correlated. This indicates that elderly living in old age homes, feels depressed and lonelier. It was found that the elderly (mixed sample) suffer from depression and loneliness in old age homes of Dehradun. A significant correlation (0.49) was found between depression and loneliness in the elderly population living in the old age homes. The results revealed that elderly females and males showed positive correlations for depression and loneliness. Females were high on loneliness (59%) and depression (61%) than males on loneliness (41%) and depression (39%). There could be various reasons for such results.

Anil et al (2019) investigated the association of depression with quality of sleep and quality of life in geriatric population in old age homes. A cross-sectional, observational study was conducted in Belagavi city across 5 old age homes. Screening of depression was done by using a geriatric depression scale (short form). 55 subjects met with the inclusion criteria. Elderly suffering from depression was the target population. The inclusion criteria were subjects scores >5. Elderly subjects in old age homes for 1 month or more. Outcome measures used for screening depression in elderly by using geriatric depression scale (Short form) then the quality of sleep assessed by using Pittsburgh's sleep quality index and quality of life using the CASP–19 scale in elderly in old age homes. GDS with CASP–19 is positive and statistically significant at 5% level (0.014). The study concluded that sleep quality and quality of life are associated with depression in older adults. There is a direct relationship between depression, sleep quality and quality of life. This finding stated that if depression can be prevented there would be an improvement in sleep quality and QOL in older individuals in old age homes.

Ayesha and Vasundhara (2019) analysed the nutritional status and disease profile of elderly (>60 Years) living in Old Age Homes in Hyderabad. The study was taken to assess the adequacy of meals, diet quality, nutritional and dietary status of elderly peoples from old age homes. A total of 120 subjects were selected, a questionnaire was developed to record health status and dietary habits. Nutritional status of respondents was assessed by 24-hour dietary survey and an anthropometric measurement BMI of each subject was calculated. It was found from MNA that out of 120 elderly people, 30% were well-nourished, 55% were at a risk of malnutrition, and 15% were found to be malnourished. The study also revealed that the nutrients, intake of energy, protein, fat, carbohydrates, calcium, and Iron were statistically lower at 5% level. The study results that high risk at malnutrition in peoples are more and it confirms the need for increased care and nutritional support among the elderly peoples. Consuming food, rich in nutrients and other bioactive components such as phytochemicals may help to protect peoples against major age-related disorders. The provision of energy-dense meals may be the first approach to increase energy intake with the fortification of food to increase the micro-nutrient intake.

Deepthi et al (2019) had analysed depression among elderly people. The study was undertaken to assess and compare the depression among elderly residing in old age homes (OAHs) and community in Visakhapatnam. The objective of the study was to assess and compare the depression among elderly residing in OAHs and those living in the community. A cross-sectional study was done among 100 elderly, of whom 50 were inmates of old age homes and 50 were living in the community selected by the house to house survey. Prevalence of depression was high among inmates of old age homes (80%) as compared to those of community (52%), this difference was statistically significant ($p=0.003$). On analyzing the association between sociodemographic factors and depression among the elderly residing in the community, it was found that marital status and presence of chronic disease were significantly associated with depression ($p<0.05$). Among the elderly residing in old age homes, no significant association was found between depression and the sociodemographic factors. High prevalence of depression observed among the studied population indicates the need for screening for depression among the elderly.

Gayatri et al (2019) had analysed self-perceived uselessness and its determinants among residents of old age homes in North Bengaluru. A cross-sectional descriptive study was undertaken on 129 elderly aged 60 years and above. Self-perceived uselessness, sociodemographic variables, morbidity status, functional status, financial status, and personal habits were assessed using a semi-structured questionnaire. Nearly half (45%) of the elderly had agreed that they had perceived themselves as useless as they age. Majority of those who perceived uselessness had one or more than one chronic morbidities and were functionally dependent (81.2%). A significant association was seen between self-perceived uselessness and functional dependency, gender, education, and having some form of activities during their leisure time. It can be concluded that self-perceived uselessness is quite prevalent in nearly one-half of the elderly in the old age homes in North Bengaluru having significant association with variables such as gender, education, leisure activities, and functional status.

Jaimika and Lavanya (2019) conducted a pre-experimental study to assess the effectiveness of pranayama to reduce the level of stress among elderly people residing in selected Old Age Homes in Delhi NCR. Pranayama is a systematic therapy for managing stress and achieving a deep state of relaxation. Convenient sampling technique was used for selecting 30 samples. Perceived stress scale was used to assess the level of stress before & after administering Pranayama. The Pranayama is given for 30 days in the morning session. The duration of giving Pranayama is 15 minutes. In Pre-test, majority (60%) of elderly people had high perceived stress, 8 (26.66%) had moderate stress and 4 (13.33%) had low stress, and in Post-test, majority (80%) of elderly people had moderate stress, 6 (20%) had low stress and 0 (0%) had high perceived stress. The results show that after taking Pranayama the elderly people shifted from high stress to moderate stress. It was evident that pranayama was effective in reducing stress among elderly people residing at old age home.

Kanchana (2019) investigated the social problems of institutionalized elderly women in Coimbatore city. The total number of elderly women present in the registered old age homes were 636, out of which 400 were selected randomly based on the inclusion and exclusion criteria. The simple random sampling technique was adopted. The result reveals that among 400 elderly women, 86(21.5%) were never ready

to move to old age home, 70(17.5%) were rarely ready to move to old age home, 83(20.8%) sometimes ready to move to old age home, 77(19.3%) often ready to move to old age home, 84(21.0%) always preferred to move to old age home. About 60% of them reported that they felt better to live in old age homes. 14 reasons were ranked out, and majority of the elderly women were ranked first for poor health conditions than for financial problem. A chi-square value for age, gender, place of the previous residence, nature of the family, marital status, educational status, occupation of women, number of children, years of stay in old age home, source of monthly income, frequency of visit by family members had an association with the reason for the elderly women to move to the institutional homes at the 0.05 level of significance.

Lidziisa et al (2019) conducted a study to assess the quality of life (QOL) and its components among the older adults staying in an old-age home and staying with family in a selected area of Kolkata, West Bengal. A total of 100 senior citizens above the age of 60 years were selected as samples for the study, of which 50 were from old-age home and 50 from those staying with family. Standardized tool Short-Form 36 Version 2 - Health Survey and Multidimensional Scale for perceived social support were used to measure the QOL. Older adults staying in old-age home perceived better QOL as compared to those staying with family. The mean score for bodily pain of older adults staying in the old-age home is significantly higher than older adults staying with family ($P< 0.01$). Fatigue scores were significantly higher in older adults staying in the family than for those in the old-age home ($P< 0.05$). The mean score for general health perception of older adults staying in the old-age home (54.7) was significantly higher than the mean score (35.9) for those who stayed with families ($P< 0.001$).

Ramamurthy et al (2019) assessed and compared the pre and post-test depression and also studied the influence of the demographic variables of those residing at old age home in Puducherry. In the Pre experimental, 48 elderly with depression were given yoga therapy for 16 weeks. Geriatric depression scale (long version) was used to estimate the level of depression of the elderly before and after the yoga therapy. Result of the study showed that at the pre-test all the elderly were having mild depression, after 16 weeks of intervention 60% of the elderly became normal. There is a significant difference in the level of depression among the elderly before and after the yoga therapy. It shows that yoga therapy had a significant impact on reducing the level of

depression. The study concluded that yoga therapy was an effective measure in reducing geriatric depression among elderly people in old age homes.

Sakshita and Kanchan (2019) analysed the depression and loneliness among the elderly in old age homes of Dehradun. The sample comprised of 60 elderly people, age group from 60 to 90 years. Beck Depression Inventory method was used to measure the level of depression among the elderly. The loneliness scale was used to measure the feeling of loneliness and social isolation. Depression and loneliness were found to be significantly correlated. The elderly suffering from depression were also suffering from loneliness. The results revealed that both elderly females and males had short positive correlations for depression and loneliness. Females' scores were high on loneliness and depression than males. Results also revealed that the old age homes in Dehradun do not have various recreational activities for the inmates that can keep them occupied and happy or allowed them to interact much with each other leading to a greater amount of depression and loneliness due to lack of companionship with other inmates. It has also been found that the duration of stay in old age homes also impacts the psychological wellbeing of the elderly.

Aayushi (2018) compared the level of depression among older adults residing at old age home and with the family in an urban community of Kolkata. The data was collected from 200 respondents. Among them, 100 were residing in old age homes and 100 were living with family. Geriatric Depression scale was used to assess the level of depression. The majority of the older adults residing in an old age home experienced severe depression whereas the majority of older adults living with a family experienced mild depression. Older adults residing in an old age home had severe depression of 4 times more than older adults living with family. Statistically, a significant relationship was found between age and level of depression of older adults residing in an old age home and older adults living with family. Finding suggests that depression among the older adults residing in an old age home was significantly associated with being unmarried, less educated, having no income, living in joint versus nuclear family and having no children. However, there was no association between depression and gender.

Bidisha Maity et al (2018) conducted a study to find out whether Total Lymphocyte Count [TLC] is a good biochemical marker for the assessment of the

nutritional status of the elderly. 125 participants were selected from Old age Home and 124 participants were selected from the community of Kolkata City. Nutritional status was assessed by the Mini Nutritional Assessment [MNA] Scale, Body Mass Index [BMI], Calf Circumference [CC], Serum albumin Level and Total Lymphocyte Count [TLC]. Participants were categorized as normal [28.9%], at risk of malnutrition [53.0%] and malnourished [18.1%] according to the total scores of MNA. A significant positive correlation was found to exist between MNA scores and BMI, CC and Serum Albumin Level. But no such correlation was found between MNA Scores and TLC.

Chaitra and Asha Bhanu (2018) conducted a study on the nutritional status of the elderly in the old age homes in Pune city. The main objective of this study was to assess the nutritional status among the elderly in old age homes and compare their dietary intake with the recommended dietary allowance. Purposive sampling design framework with inclusion and exclusion criteria was used to identify the respondents for the study. A sample size of 131 elderly was assessed. The tool used for assessment included 24-hour dietary recall and anthropometry which was analysed using statistical package for the Social Sciences. About 46 per cent suffered from malnutrition which was analysed in the form of under and over-nutrition. 11.5 per cent were underweight, 26.2 per cent were overweight and the rest of them belonged to grade 1 and grade 2 level of obesity. The study indicated a high prevalence of malnutrition among the elderly living in the old age homes. This indicates that there is a need to improve healthy eating habits at an institutional level.

Chew et al (2018) studied about elderly people in old age homes and emerging factors leading to institutionalization in Malaysia. The aim of this study was to explore and understand the elderly peoples' perspective on emerging factors leading to their admission into old age homes. Purposive sampling was adopted and 12 residences from two old age homes were interviewed using a semi-structured interview schedule. Findings revealed that, elderly people perceived their admission are due to societal changes and modernization in the lifestyle, their poor health, reduced mobility and changing family structure. They do not harbour feelings of anger and abandonment on their families' decision but maintain a good relationship with their family. They realised the best option for them is to be admitted into old age homes where they can be cared for full time by trained personnel. Overall findings indicated that elderly people

were satisfied with their lives living apart from their own family and assisted by living in old age homes.

Dasarath et al (2018) had investigated the reasons for the living of elderly people in old age homes in Nepal. The objective of this study was to explore the factors compelling elderly people to reside in old age homes. This study was carried out on 22 elderly residing in old age homes in Nepal. Factors responsible for their setting in old age homes were explored by using the interview method. Loneliness (31.8 per cent), poverty (27.3 per cent) and having no son or daughter (27.4 per cent) were found to be the most common reasons for residing in old age homes. Many elderly people in Nepal were opting old age homes as their place of stay in their later life. Foreseeing the future, the government and voluntary agencies in Nepal must make arrangements for institutional support and care for the elderly.

Devika and Hema Mala (2018) analysed the perceptions on service quality of old age homes in Kerala and Tamilnadu. It has been found from research that the setting of old age homes and the employees influence the welfare of the residents and their healthcare. Despite various services provided researches have concluded that service gaps exist among staff and residence of old age homes. The purpose of this paper is to draw or in site from an in-depth analysis of old age homes and to study the perceptions in service quality of old age homes by studying old age homes in the Indian states of Kerala and Tamilnadu. Analysis of the collected data shows that responsiveness and empathy for the dimensions that are to be improved in both states, to increase overall satisfaction levels and to meet the expectations of residents. The quality of the attributes 'cleaning services for rooms', ' freedom to plan on time' and 'respect for residence privacy' shall be improved by old age homes in order to improve the perception of service quality by residents.

Harasankar Adhikari (2018) examined determinants of contextual relationship and effects on ageing population in India. Data collected purposively through random sampling. It revealed that 86% of the elderly population lived with hunger. They did not involve in paid work because they had no support from offspring/relative. They had no social security measures excluding 22% informants who were under government social security measures, i.e., Old age pension and widow

pension. They did not get assistance for health care when almost all of them suffered from dental and cataract problems.

Help age India (2018) conducted a survey on elder abuse in India. This study aimed to understand the spread type and extent of elder abuse in India with impact of social media and technology and awareness of elders on redressal measures. The study covered 5014 elders across 23 cities. Around 60% of elders confirmed that elder abuse is prevalent in our society. Nearly one-fourth elders (25%) have confirmed that they have been the victim of elder abuse ever with no gender variation. The most common form of abuse they experienced was disrespect (56%), verbal abuse (49%) and neglect (33%), the main abuses were son (57%) and daughter-in-law (38%). Only 18% of elders have confirmed that they have made an attempt to report abuse and only 35% of the total reporting was successfully resolved. 65% elderly stated that extreme attention given to phones and computers was disrespectful. It was concluded that social security of elderly should be taken care by giving opportunities for income generation programs to sensitize children and young adults and by involvement of society at large against elder abuse should be initiated.

Nnachi (2018) conducted a study to determine the ideal age older adults would choose to be if they had the power to make themselves older or younger and to identify their reasons for the choice of that ideal age. The sample size was 1105 older adults of both male and female aged between 60 and 96 years. Results show that many of the respondents choose between 20 and 39 years as their ideal age. The major reasons included health and physical strength, to correct past mistakes and achieve unfulfilled dreams. The elders recommended exercise, good dietary practices, observing natural laws, and appropriate medication,

Prajna Pani (2018) stated that the use of mobile apps can contribute to the new active ageing paradigm. The objectives of the study were: a) to understand the needs and difficulties of the seniors, b) to explore the innovations and c) to facilitate holistic development by creating an m-enabling environment. The mobile apps have profound implications for seniors. This article has reviewed the literature and best apps that can address some of the needs of the seniors. People everywhere must age with dignity and security enjoying life through the full realization of all human rights and fundamental freedoms.

Prakrit et al (2018) have investigated children's migration and its effect on elderly people in old age homes of Kathmandu Nepal. The main objective of this study was to assess the impact of out-migration of children on the elderly parents staying at old age homes. The total sample size was 33 and two case studies were carried out. The main age of the respondents was 75 years. Majority of the participants were female, almost half were illiterate and nearly two-third had no income source. There were various reasons for not staying with their out migrator children like illness, children not having time to take care of their parents, children did not like to live with their parents, adjustment problem in the new place and desire to die in their homeland. Due to Migration of their children half of the respondents had a physical problem, 78.8 per cent had emotional problem whereas only a few respondents had economic and social problems. With the increasing trend of both internal and external migration of youth, elderly parents have leftover alone in their homelands or some old age homes.

Priyanka et al (2018) conducted a comparative study of health status and quality of life of elderly people living in old age homes and within family setup in Raigad district of Maharashtra. The main objectives of the study were to assess and compare the health status, quality of life and depression of elderly people living in old age homes and within the family set up. WHO QOL questionnaire and Geriatric Depression scale were used. 60 elderly from old age homes and 120 elderly living within family set up were selected randomly. The quality of life of elderly in domains of autonomy, past, present and future activities, social participation and intimacy were better in the family setup as compared to old age homes inmates. There was a statistical significant difference in mean depression scores of both the groups. Quality of life of the elderly within the family setup was better as compared to the elderly in old age homes.

Hom Nath et al (2018) analysed the health status of elderly living in government and private old age homes in Nepal. A cross-sectional descriptive study was carried out in Kathmandu and totally 7 old age homes were included in this study. The total sample size of this study was 188 and in-depth studies were also carried out. Results revealed that the elderly people living in the private old age homes have a better health status than the government old age homes despite the minimum amenities available. The elderly in government old age homes suffered more to endemic diseases

than private old age home inmates. Following the healthy habits and the clean dwelling surroundings of the private old age home had let their health a better as compared to the government old age homes. It was concluded that the government should give priority to provide the quality of services to the elderly living in old age homes.

Sayani and Shivani (2018) analysed frailty pattern among the elderly rural women of India. Frailty was assessed using a modified version of Women's Health and Aging Studies (WHAS). The relationship of frailty shows a positive correlation with age, major occupation, socio-economic status, body mass index, self-reported health status, number of falls and chronic diseases. It was concluded that frail significantly associated with the ageing process. So, for healthy ageing as well as preventing or delaying more severe clinical consequences, we need to identify all the aspects of frailty.

Sivakumar et al (2018) investigated the oral health-related quality of life of institutionalized elderly in Satara district of India. The aim of this study was to assess the oral health-related quality of life and the dental care utilization of institutionalized and homebound elderly in Satara district. The descriptive cross-sectional study was conducted among the 150 institutionalized elderly participles. Poor OHRQOL according to GOHAI observed among 64.7 per cent of men and 67.1 per cent of women and there was no statistically significant difference observed. In community periodontal index 42.6 per cent of men and 36.6 per cent of women had all sextants excluded, and of those remaining 95.6 per cent of men and 96.3 per cent of women needed one or other periodontal treatment. Regarding decayed missing and filled teeth index main was 22.5 in men and 24.2 in women. Institutionalized elderly with 65 years and older showed a higher prevalence of poor oral health status and unmet needs for Dental Care, associated with poor OHR QOL. Therefore it is necessary to improve health and social importance of oral health care for the elderly.

Sourav and Pradeep (2018) analysed how elderly staying alone, cope up with their age and deteriorating health in rural Vardha Central India. This study was done to explore the various changes and problems faced by the elderly people staying alone and how they cope up to maintain their life amidst the physical, family, social and financial crisis in their lives. Elderly above 65 years of age of either sex, living alone in their own houses for at least 2 years were included in the study. 24 such individuals

were selected. Results revealed that the elderly staying alone face the problems of lack of family, social and financial support in their day to day life. They cope up with these problems by a number of ways. Although there were a number of government schemes to protect the elderly, none of these policies was dedicated to this special group of elderlies. There is no social structure that can take care of this vulnerable group of elderlies in rural India. It is a right time for the government to step in to bring some societal and family reforms that will safeguard the elderly staying alone from the ongoing family, social and financial hardship.

Sowmyashree and Shivalingappa (2018) conducted a study about socio-economic and health status of elderly in rural and urban areas of Mysore District. The study was based on a field survey. Totally 570 elderly were interviewed. The study revealed that elderly women had relatively poor socio-economic and health status, especially in urban areas. Therefore, it was concluded that elders especially women needed better care and more facilities from the government and their family.

Sunita and Thomas (2018) explained the status of the elderly and the emergence of old age homes in Bengaluru, India. Older adults living in old age homes face problems of adjustment with tight and rigid schedules, total separation from the family, friends and society, anxiety over and entrusting oneself to a new environment, diminished physical ability and frequent encounters with death and ailments in the institution. The issues of elder security and wellbeing are becoming a matter of concern. There is a need to take care of older adults with a focus on social and mental wellbeing, economic and social security and elder abuse. However, there is a need to create awareness among older adults and their families and caregivers of old age homes about the needs, experiences and coping styles of older adults. It would be more beneficial to empower older adults to be emotionally by branch about leaving positive and fulfilling lives.

Yesaswini (2018) analysed the contribution of visual and auditory inputs on balance during dual tasks in health of older individuals. A total of 43 older adults were selected in this observational study. Based on the findings it was concluded that an auditory distraction with timed up and go test on balance control is more challenging than timed up and go test with visual distraction.

Agewell Research and Advocacy Centre (2017) described the financial status of older people in India. A set of specific objectives have been framed to analyse the financial status of rural and urban elderly. A total of 15,000 respondents were studied by 500 volunteers across all the five regions of northern, southern, western, eastern and central India. Result revealed that there was no source of income for 5.27 per cent respondents. Two-fifth of the respondents (40.6 per cent) stated that their monthly income was up to Rs. 5000. 18 per cent claim to be living all alone and the family members were settled abroad or living in other places. Among respondents, 42 per cent disclosed that they are dissatisfied or very dissatisfied with their current financial condition. 99.4 per cent of older persons claim that their financial status is very much critical. More than four-fifths (82.7 per cent) of subjects shared the fact that the major problems are related to medical and healthcare. About one third (34.2 per cent) respondents have been facing problems primarily due to financial issues.

Aminul Islam (2017) conducted a study about the socio-economic conditions of the rural elderly in Bangladesh. 203 elderly were selected randomly. The findings revealed that the majority of them have no formal education and earn below Rs.2000 per month. About 64% of the elderly are leading their life without sanitary latrine and 72% of them are taking a bath without a bathroom.

Dipeshkumar et al (2017) conducted a comparative study of depression and associated risk factors among elderly inmates of old age homes and community of Rajkot**.** All the eligible 88 elderly residents of six OAHs and 180 elderly residents from the same city were administered with a pretested semi-structured questionnaire having the GDS-G form. The elderly of OAHs were more depressed when compared to those of the community. Older age, females, weaker family ties, poorer self-perception of health status, presence of chronic ailments, absence of recreational activity, lack of prayers, impaired sleep, and history of addiction emerged as the predictors of depression in both the setups. More health complaints and a later self-perception of the visit to a doctor were found among the depressed than the non-depressed in both the setups. Depressive symptoms were quite high among the elderly in both the setups. Special attention should be given towards health check-ups of depressed persons in the OAH and improvement of family ties among depressed persons of the community.

Jerin Mathew et al (2017) evaluated the feasibility of kinematic gait parameters in institutionalized 40 geriatric population using easily available software and associated objects of evaluation, The findings of this study revealed that recording and analysis of gait, using Kenova software webcams is a feasible and objective method of gait analysis to detect abnormalities that may predispose to falls in the elderly population. This will help the rehabilitation practitioner to plan and implement gait strategies and interventions, thus reducing the risk and incidence of fall in the elderly population.

Justin and Shanuga (2017) examined the determining effect of age identity, stigma and discrimination on psychosocial disability in older persons. 573 older persons aged 65 years and more, living in families and in elder care facilities were selected by using a multi-stage cluster sampling procedure. Age identity, stigma and discrimination have significantly determined by psychosocial disability and explained 64.3 per cent of the variance. The study concludes that age identity, stigma and discrimination have significantly increased psychosocial disability, disposing of older persons vulnerable to social exclusion.

Ogundare et al (2017) aimed to identify factors that influence health and quality of life (QOL) specifically in rural dwelling elderly Indians. A cross-sectional survey of 352 elders from 10 villages near Pune Maharashtra, India was conducted to measure the prevalence of 15 dimensions of health; Vision, hearing cognition, mental, social, physical activity, substance use, physical-strength, independence in activities of daily living, Instrumental, ADL, dental, nutrition, chronic pain, sleep and safety. On the basis of findings, it was concluded that to achieve comprehensive health and QOL in elderlies a proactive and diverse approach for optimizing all the significant dimensions of health should be adopted. This is particularly important in rural areas, where available medical resources may be limited when it comes to addressing elderly health decline.

Panday et al (2017) investigated adjustment among elderly living in old age home and within a family setup. Adjustment is a process involving both mental and behavioural responses by which an individual strives to cope with inner needs, tensions, frustrations and conflicts and to bring harmony between these inner demands. Aim of this study was to assess and compare adjustment among elderly people living in old age

home and within the family setup. A cross-sectional research design was used. The sample comprised of 80 participants (40 participants who were living in old age homes and 40 participants within a family). Socio-demographic datasheet and Adjustment Scale were administered. Findings indicate that adjustment was good for elderly people who were living in old age home in comparison to elderly living within a family. Present study findings would help in implementing the rehabilitation program for elderly people.

Rishi and Pradeep (2017) investigated the quality of life among elderly living in old age home in New Delhi. Quality of life is widely recognised as an important concept and measure of outcomes in Healthcare. This concept is emerging more and more often also in connection with long term care. For minimising the gap between old age homes and the family there is a need to raise the awareness about ageing in the community and amongst health professionals and to improve the access to appropriate health care for the elderly. Educating about ageing the other family members particularly the young on their role in keeping the elders happy and active and to support them physically, socially and environmental is equally important.

Tattwamasi and Renu (2017) conducted a study in Gujarat to explore the role of elderly in the household domain with an intergenerational perspective. 69 elderly from the family setting and 11 elderly from the Old age Homes were interviewed individually. It was found that the various factors influence the relationships between the elderly and their family members. The study concludes with the relevance of healthy interaction for better intergenerational bonding in the family.

Anitha et al (2016) have compared the quality of life (QOH) among elderly living in old age homes and community with the association of various socio-demographic factors, spouse factors, habits and hobbies. 49 subjects from old age homes and 48 subjects from the community were administered after taking informed consent. The factors associated with quality of life in both groups were analysed statistically. It was concluded that, socio-economic strata have got the highest association with QOL. High QOL is seen among OAH inmates when compared to the community-dwelling elderly. There was no major difference in QOL between the two groups. However, the association of various socio-demographic factors and other factors with QOL was statistically significant.

Anjali and Sunita (2016) conducted a study on institutionalized and non-institutionalized elderly people. The aim of this study was to assess and compare the ageing in institutionalized and non-institutionalized elderly people in Lucknow. The instruments used were satisfaction with life scale (SWLS) and psychological scale. The total sample was 120 elderly people. Among them 60 were institutionalized and 60 were non-institutionalized in the age group of 62 to 85 years. A statistically significant difference was found between institutionalized and non-institutionalized older adults. The study revealed that the majority of the elderly had not satisfied with life live-in institutionalized.

Diwakar and Nanjesh (2016) analysed the morbidity pattern among inmates of residential ashram in rural Dakshina Kannada district. The study was undertaken to assess the health status and socio-demographic profile of inmates staying in the residential Ashrams and planning of healthcare services for them. A cross-sectional study was done among the inmates of residential ashrams in the rural field. The study comprised 179 inmates. 23.5% of the adults were illiterates. 22.3 per cent of adults were suffering from two to three types of morbidities. The morbidity pattern of inmates was mainly anaemia (64.2%) followed by hypertension (51.9%) and joint problems (44.1%). The other problems include gastrointestinal symptoms (27.4%), visual acuity problems (24%), respiratory symptoms (22.3%), obesity (20.7 %) and diabetes (17.3%). The study showed nearly all inmates suffered from one or more type of illness, the most common being anaemia, hypertension, and joint problems. Hence there is a need to address the health problems of inmates staying in residential Ashrams.

Government of India (2016) published a report 'Elderly in India profile and programs' in 2016. The report revealed that according to population census 2011 there are nearly 104 million elderly persons aged 60 years or above in India. 71% of the elderly population resides in rural areas while 29% in urban areas. The life expectancy at birth during 2009-2013 was 69.3 years for females as against 65.8 years for males. The old age dependency ratio climbed from 10.9% in 1961 to 14.2% in 2011 for India as a whole. In rural areas, 66% of elderly men and 28% of elderly women were working while in urban areas only 46% of elderly men and about 11% of elderly women were working. The literacy rates among elderly female (28%) was less than half of the literacy rate among elderly males (59%). Prevalence of heart diseases among the elderly

population was much higher in urban areas than in rural areas. Most common disability among the aged persons was locomotor disability and visual disability as per Census 2011.

ICMR (2016) conducted a workshop on ageing and health in India, the overall objectives of the workshop was a) to identify common areas of research and possibilities of mutual learning, b) to share useful practices and lessons of researchers, c) to identify themes and models for further exploration. The speakers from two countries (India and Sweden) described the mental health care services provided to elderly persons and discussed the various determinants of health conditions in this population.

Isha (2016) conducted a study about quality of life in old age homes in Punjab. The study highlighted the reason for the elderly to move to Old age homes. It was focused on Government and Non-Government Old age Home's role in providing facilities to the Institutional elderly as an alternative form. The study was conducted in different old age homes of Punjab state by taking a sample of 311 Institutionalized elderly. It was revealed that family conflict was one of the major reasons for shifting into old age homes. The results indicate that there was a high prevalence of Institutional facilities and service and level of satisfaction in non-government old age homes as compared to government-oriented old age homes.

Nagesh Jamwal (2016) examined psychosocial consequences among elderly living in institutional and non-institutional settings in Jammu district. The research was conducted to study the quality of life, loneliness and psychological distress of the elderly males and females living in institutional and non-institutional settings in urban Jammu district. Using purposive sampling method, 40 elderly living in institutional settings and 40 elderly living in non-institutional settings, in the age of 60 to 80 years, interviewed. Three tools were used in this study. They are 1) GHQ, 2) UCLA loneliness scale and 3) WHOQOL-Bref. Findings revealed that there is a significant difference in physical health, psychological health and social relationships which indicate that elderly living in institutions have diminished quality of life in comparison to elderly living within a family setup. Majority of elderly have a low quality of life and are lonelier than those living with their families, this disturbance demands preventive psychological interventions for the aged population.

Pradya and Ragupathy (2016) investigated the prevalence of risk factors for falls among elderly people living in long-term care homes. Identifying risk factors for falls in old-age homes can help in the care and prevention of falls in this population. A total of 163 elderly men and women aged 60–95 years were studied. History of falls revealed by participants, Long Term Care Fall Risk Assessment Form, Mini-Mental State Examination, Berg Balance Scale, Fall Factors Assessment Form, and Dynamic Gait Index were used as the assessment tools in this study. The following risk factors were significantly associated with falls: poor vision, chronic conditions, vertigo, imbalance, fear of falling, and previous falls (all $p < 0.001$). There was a significant difference between high-risk and low-risk groups for all functional and cognitive measures. Women had a higher risk of falls than men.

Sarin et al (2016) examined depression and hopelessness in Institutionalized elderly in New Delhi. The purpose of this study was to examine the presence and severity of depression and the extent of negative attitudes about the future in Institutionalized elderly in India. Data were collected by administering the Beck Depression Inventory [BDI] and Beck hopelessness scale [BHS] on residents of different old age homes across Delhi NCR [N = 21]. Results revealed the presence of mild depression and mild hopelessness in the institutionalized elderly. A positive strong correlation was found between depression and hopelessness, social and emotional losses associated with institutionalization lead to depressive responses in the elderly. The findings of the study draw attention to the neglected and apathetic conditions of Institutionalized elderly and imperative concern for the Indian Society.

Suresh and Srikanth (2016) have analysed the depression and psychological well-being among institutionalized and non-institutionalized elderly in Andhra Pradesh. This study was an attempt to find out the main difference between depression and psychological well-being among institutionalized and non-institutionalized elderly. The geriatric depression inventory and psychological wellbeing scale were used on the elderly population. A total of 60 samples were taken, out of them, 30 were from old age homes and 30 were from non-institutionalized elderly in Tirupathi Chittoor district. Results revealed that there was a significant difference in depression and psychological well-being with respect to institutionalized and non-institutionalized elderly.

Usha et al (2016) evaluated morbidity profile of inmates in old age homes in Mangalore. The objective of this study was to assess the morbidity and socio-demographic profile of inmates. Universal sampling was done to obtain a sample size of 80 from three old age homes. Among the inmates 25% were male and 75% were female. Out of which 63% were in the age group of 60 – 70 years. Among the elders 69% were widows, 55% did not have any source of income, 29% were illiterate and 46% had completed primary education, 75% had musculoskeletal disorders, 69% had visual defects, 64% were hypertensive, 30% had dental problems and 28% had diabetic.

Usha Rani et al (2016) examined the level of stress among elderly at selected old age homes in Nellore. A total of 100 samples were included by using a non-probability convenience sampling technique. The result shows that 3% have mild stress, 86% have moderate stress and 11% have severe stress. The mean score of stress scale is 153% with a standard deviation of 21.8, stressors mean is 19.44 with a standard deviation of 7.50 and life events mean is 32.6 with a standard deviation of 11.15. In the association between the level of stress among elderly people residing in old age home with their socio-demographic variables like age, gender, education, marital status, source of income, habits, coping mechanisms used to specify and co-morbid diseases were significant at the level of $P < 0.05$.

Vineeth and Jasmin (2016) stated that sleep disturbances are more prevalent among the elderly and act as a major source of stress for them. Aromatherapy is the method of using pleasant fragrance in treating the different health problems of the people. The aim was to study the effectiveness of aromatherapy on quality of sleep among elderly inmates. Sixty inmates from selected old age home were assessed for the general pattern of sleep. Among them who were having fairly and inadequate sleep were selected for the study. Aromatherapy was administered for five consecutive days. The lavender essential oil was dropped on a cotton ball and kept under the pillow throughout the night. The quality of sleep was assessed before aromatherapy, as well as on the third and sixth day using Modified Pittsburgh Sleep Quality Index (PSQI). The mean pre-test PSQI score (11.9) was significantly higher than the post-test score (4.875). The study revealed that quality of sleep was poor in the elderly before aromatherapy and the quality of sleep increased by aromatherapy and it was concluded that aromatherapy is useful in increasing the quality of sleep among elderly inmates of the old age home.

Achariah et al (2015) investigated the quality of life and functional status of inmates of old age homes. The objectives were a) to study the quality of life of inmates using SF36 QOL and b) to assess the functional status of inmates using the Barthel Index. It was concluded that based on the scores of SF 36 QOL the quality of life of inmates was moderate and the majority of inmates' functional status was poor.

Ambati Nageswara Rao (2015) conducted a study to find out the quality of life and the coping strategies of the inmates of old age homes in the city of Ahmedabad. 50 inmates from five old age homes were selected through the random sampling method. The elderly subjects were interviewed individually to find out the reasons for coming to live in old age homes and to know their views about the living conditions and their coping strategy in the new environment. Findings revealed that inmates were highly dissatisfied with the behaviour of their children. The respondents were of the view that in old age when health deteriorates and the person is unable to work his self-respect is badly hurt.

Ananthlaxmi et al (2015) studied the prevalence of depression in older adults living in old age home. A cross-sectional study was carried out in two old age homes in Ahmednagar. 80 participants living at old age homes, in the age group of 60 to 85 years were included in this study. The prevalence of depression in older adults living in old age home was 53.75%. An increase in depression cases was found as the age increases. e.g., young old [47.92%], mid old [57.69%] and old-old [83.33%], percentage of depression in female [58.82%] was more than men [44.83%], percentage of depression according to marital status was found higher in widows [67.57%]. Addressing some of these issues may contribute to improve the quality of life of older adults and decrease the burden on family, society and the nation.

Chandrika et al (2015) studied the quality of life of elderly residing in old age homes and community in Visakhapatnam City. The quality of life of the elderly was assessed using the WHO QOL BREF questionnaire. The main scores of cuboid were better among the age group of 65 to 69 years, male, married and literate. The main score of physical, psychological, social and environmental domains were 51, 66, 47 and 52. The mean score of QOL in physical and social domains was better in elderly living in the community than old age homes. QOL domain environmental was better in elderly living in old age homes than community. Least scores were obtained on the social

domain among the elderly as compared to the rest of domains irrespective of place of stay.

Deotale et al (2015) conducted a study of morbidity profile of elderly at old age homes and its association with disability in Maharashtra. The main objective was to assess morbidity among elderly residing at OAH and to determine the relationship of morbidity with a disability and socio-demographic factors. A descriptive cross-sectional study was conducted among elderly people with the age of above 60 years, residing at 3 OAHs in Amravati district. The diagnosis was made on clinical examination, cross-checking of medical records and significant was used for statistical analysis. Result revealed that most common form of morbidity was problems [61.8%] followed by musculoskeletal problems [53.9%], Anaemia [32.4%], HT [30.4%] etc. 64.7% were having some form of disability. Morbidity and number of morbidities both were significantly associated with disability (P = 0.000). Age was significantly associated with morbidity (P= 0.000). They concluded that geriatric units are essential with specialized professionals along with subsidized health care services in order to address geriatric morbid conditions in a proper manner.

Hussain and Manzoor (2015) analysed antecedents of an increasing trend of old age homes in Lahore, Pakistan. The study was carried out in district Lahore to critically analyse the consequences and socio-economic factors which leads the elderly people to reside in the shelter homes. The sample was comprised of 60 inmates. Results revealed that the majority of the older people (73.3%) were unemployed and they depended on their descendants to maintain them economically. Memory status and physical conditions of the old persons depict that 58.3% had normal memory to interact with people, 30% had minor mental weakness and 11.7% had much mental weakness. The study also reveals that 44.7% of respondents appeared in normal physical condition, 30% looked physically weak and 28.3% had a relatively bad health condition. Majority of respondents (51.7%) had no opportunity of social contacts with neighbour relatives. The study highlights the phenomenon of loneliness among older people and its associated health risks, such as the link between declining mental health and physical health problems that compromise their quality of life.

Lokare et al (2015) assessed the quality of life among the elderly population residing at old age homes and its association between the socio-demographic

factors Amravati city, Maharashtra. A total of 102 participants were included in the study. The participants were interviewed with a questionnaire for Quality of life including four domains, that is, physical, psychological, social relationship and environmental. Mean score value of quality of life was 76.30 among the elderly population. The overall quality of life and health perceived by the elderly in old age home was 3.2 and health-related quality of life score was 3.0. The physical ill-health indirectly affects social domain score as the person becomes dependent on others due to limitation of mobility. Involvement in social activities is also restricted. The longer duration in old age homes affected psychological domain score of aged people. There are need age-friendly communities that provide their citizens with more opportunities for social activities and worthwhile leisure time pursuits.

Mallika et al (2015) analysed the denture acceptance among the newly rehabilitated elderly population in old age homes in South India. The aim of the study was to observe and determine the acceptance of new dental prosthesis among the elderly residing as inmates of 3 old age homes in Mangalore city. Results revealed that out of 400 residents, 183 residents were denture wearers. Among them 101 were females and 82 were males. Dental prosthesis whether worn regularly discomfort retention cleansing of the denture during a period of 1-month, 3- months and 6-months was found to be significant. Satisfaction with the prosthesis, denture adhesives used, food accumulation during a period of 1 to 6 months was found to be non-significant.

Paul Zammit (2015) analysed about depressive illness among institutionalized older people in Malta. 150 patients living in nursing homes in Malta were included in the study. The geriatric depression scale was used to identify depression. Data for risk factors for depression and the management of residents for this pathology was also collected. 67.3 per cent were found to be depressed. 12 per cent of the total population had major depression while 55.3 per cent had minor depression. Significant associations included low bethel scores, loneliness, being currently in pain, taking several medications, being widowed and having osteoarthritis. The study also showed that those residents already diagnosed with depression were being treated inappropriately with low prescription levels of antidepressants. Research shows that depression in nursing home residents is highly prevalent and underdiagnosed. There is also a lack of proper treatment in those identified with depression. There is a need for

further research to develop intervention and management strategies for depression that is specifically tailored to meet the needs of the trial nursing home population.

Punit et al (2015) analysed the medico-social profile of the inmates of old age homes. A descriptive cross-sectional study was conducted in Gujarat to assess the socio-demographic profile, pattern of morbidities and quality of life of elderly residing in old age homes. Totally 4 old age homes and 203 elderly people were included in the study. Around 65% of elderly people were in the age group of 65 to 79 years. 58% of the males and 39.1 % of the females were suffered from cataract, whereas 39.8% of males and 39.1 % of females were suffered from hypertension. Next common morbidity was diabetes present in 28.4% of the males and 18.3 % of the females followed by joint pain present in 20.5% of the males and 23.5% of the females. No significant difference was found among morbidities of the males and females (x2=2.85, p=0.35). 30.8% of the males and 28.75% of the females were hypertensive. Around 27% of the males and 36% of the females were obese and 18% of males and females were pre-obese according to BMI value. There was no significant difference in BMI among males and females. The study highlighted a high prevalence of morbidity and health-related problems in old age homes.

Sabiha et al (2015) have assessed the oral health status and treatment needs among elderly people aged 60 years and above residing as inmates in the old age homes of Hyderabad and Secunderabad in Andhra Pradesh. In order to assess the oral health status and treatment needs, the clinical assessment of oral mucosa, community periodontal index, loss of attachment, dentition status and treatment need, prosthetic status and the prosthetic need was recorded based on a modified World Health Organization 1997 report. Of the 812 inmates, 431 (64.0%) of the study participants had oral mucosal lesions. In terms of periodontal status, all sextants were excluded (Code "X") in 324 (39.9%) subjects. Out of the dentate population, a majority of the inmates (219; 27.0%) presented with deep pockets followed by shallow pockets. The majority of the subjects had no prosthesis in the upper arch (85.0%) and a lower arch (86.6%). The study demonstrated poor oral health among institutionalized elderly inmates. Oral mucosal lesions were found to be higher and periodontal status was also poor amongst the study population.

Susmita et al (2015) have conducted a study about stress and coping strategies among senior citizen in selected old age homes in Berhampur. The objectives of the study were to find stress and coping level and find out the association between stress and coping strategies of a senior citizen in an old age home with their selected demographic variables. The sample size comprised of 33 senior citizens. The analysis showed that the overall stress mean score (60.0 + - 7.28) which is 60.6% of the total score, shows the moderate stress of senior citizen and overall coping strategy mean score which is 68.9% of the total score shows that there is a moderate level of coping among senior citizen.

Shaphiya (2015) conducted a study about old age homes in Andhra Pradesh. The study focused on the socio-economic and societal implications of old age homes. The survey was conducted on 37 old age homes spreading over 8 districts in Andhra Pradesh. Among the total 1029 elderly persons, 410 were men and 619 were women. Results revealed that 22 were free old age homes, 36 homes had got televisions, and 31 homes offer regular medical facilities and the majority of inmates suffered by emotional stress.

Shwetha Maktha and Vijay Kumar (2015) have analysed the level of depression among elderly residing in an old age home in Hyderabad, The study was designed to evaluate the depression among elderly in old age home and to recommend suggestive measures to prevent or reduce it. 80 elderly clients were interviewed using a pre-designed pre-tested questionnaire; assessment of depression was done by using Beck's depression inventory. Results revealed that the mean age of the respondents was 67.4 + - 4.7 years with the majority in 66 – 70 year age group (61%) and 55% were males. Mean depression score was 21.64, maximum of (39) elderly clients (48%) had moderate depression and 23 (29%) had mild mood disturbance. It was concluded that prevalence of depression was high in the present study and the associate factors were increased age; in females and with duration of stay in old age home.

Tiwari et al (2015) tried to develop a scale to assess the satisfaction and expectation of older adults in Old Age Home. This study was a cross-sectional study design. The initial draft of the questionnaire had 5 domains viz. physical structure, services provided, lifestyle, financial and social relationship comprising a total of 26 questions. Each question was on a 5-point Likert scale (lowest being 1 and highest

being 5). The Cronbach's Alpha was >0.50 for all the items indicating the better reproducibility of the questionnaire with the significant intra-class correlation coefficient. Majority of the domains were significantly correlated with each other, although the correlation coefficient was not high indicating a better understanding of the questions as well as scores to be responded. The Cronbach's Alpha was >0.60 for all the domains when scores were added within each domain's questions with the significant intra-class correlation coefficient. The new scale appears to be valid and reliable for assessment of satisfaction and expectation of the residents in Old Age homes.

Anitha et al (2014) were conducted a cross-sectional comparative study assessing the psychiatric morbidity in elderly living in old age homes and community in Telangana. 50 subjects from each of old age homes and community were administered Geriatric Medical Status questionnaire after taking informed consent. The social demographic factors and psychiatric morbidity of the two groups were analysed statistically. Significant differences were found between the two groups in socio-demographic factors like age, educational status, socioeconomic status, marital status, having no male children and having employed children. Moderate depression, obsession and alcohol use were found to be higher in the community group whereas mild depression cognitive impairment and somatic dysfunction were found to be higher in old age homes, but statistically not significant, except for alcohol use. They have concluded that elderly people in old age homes and community differed in socio-demographic factors but not much in psychiatric morbidity.

Bindu et al (2014) assessed the health status and examines types of health problems based on knowledge, awareness and perception of the inmates in two old age homes in Vadodara city. A total of 50 inmates from two old age homes were interviewed. It was observed that major health problems found among inmates were blood pressure 54%; weakness 44% followed by pain/ tingling in lower limbs 38%, disturbed sleep 36%, and breathlessness 32%. Back pain, gastric problem thyroid, heart attack, arthritis and hysteria problem was also observed. Two inmates were suffering from paralysis. There were four diabetics. Two inmates had T.B in past. It was observed that the majority of inmates were suffering from health problems associated with ageing. The elderly comprise a very important vulnerable group is ignored but needs urgent attention.

Chalise (2014) conducted a study about depression among elderly living in Briddashram (OAH) in Nepal. The purpose of this study was to determine the prevalence of depression and its predictors among elderly living in OAH. The samples (185) were elderly aged 60 years and above. The finding shows the prevalence of depression was 57.8%. Among them 46.7% had mild, 8.9% had moderate and 2.2% had severe depression. A statistically significant correlation was found between feelings of depression and age, sex, previous family type, ethnicity, feelings of loneliness and instrumental activities of daily living. Regression analysis shows that being women, feeling of loneliness and higher the dependency in IADL were predictors of depression. This study indicates that there should be some interaction from the concerned authorities so that depression can be reduced which will support the wellbeing and quality of life of the elderly.

Marlene et al (2014) analysed depressive symptoms in institutionalized and non-institutionalized individuals in Portugal. This study aims to assess the association between institutionalization and depression in the elderly. A cross-sectional study was conducted with a group of elderly people aged 65 years or more. The Great Depression scale (GDS) was applied. The sample was composed of 75 elderly people aged between 65 and 91 years. 44 were institutionalized and 31 lived in the community. The prevalence of depressive symptoms was higher in single and widowed elders than in married elders. The livelihood of having depression symptoms was 74.1 per cent lower in non-institutionalized elders. The fact that the elders' under study lived alone, were widowed and were institutionalized seems to clearly contribute to the presence of depressive symptoms. It would be of paramount importance to find therapeutic strategies to minimize the impact of institutionalization.

Geetha et al (2014) conducted a study about the level of stress and its correlation among residents of old age home in Kanchipuram. A descriptive, cross-sectional study was conducted among 100 inmates of old age homes. It was observed that nearly 18% of the participants had high-stress scores and 60% had moderate stress scores. Gender, co-living status with spouse was found to the signs associated with stress scores. The perceived stress was high among inmates. There is a need for organized family and social support to improve the physical and psychological health of the elderly.

Jharna et al (2014) have stated the assessment of subjective well-being status of elderly people in old age homes in Kolkata in relation to their perceived physical health and cognitive functioning. The data were collected from 50 elderly people who were selected by total enumeration sampling from two different old age homes in Kolkata. They were assessed using the Subjective Well-being Inventory and a self-developed checklist for perceived physical health problems. Cognitive function was assessed by using the Mini-Mental State Examination. More than half (52%) of the elderly people have reported high subjective well-being status. Regression analysis showed that perceived physical health problem ($P < 0.001$) and having children ($P = 0.010$) were statistically significant predictors of subjective well-being. Improved psychosocial aspects can increase perceived physical health and subjective well-being.

Joseph et al (2014) conducted a study about life satisfaction among inhabitants of selected old age homes at Chandigarh. The study was conducted among inhabitants of four urban old age homes. Satisfaction with life was assessed with the aid of a five item scale (SWLS). The affective components of psychological wellbeing were assessed by the geriatric depression scale (GDS). 50 subjects participated in this study. More than half of the participants were employed in the private sector. 26 participants expressed that their life was not close to their ideal and scored low satisfaction with life. There was no association in satisfaction with life as per gender. The mean score of the geriatric depression scale was 15.04 with the standard deviation of 7.29 and most of the participants scored in the middle depression category as per geriatric depression score. This study also revealed that the majority of the inhabitants in this old age homes setting were literate, married with the urban background. More than half of the participants expressed moderate psychological wellbeing as per test scores.

Komal et al (2014) have investigated the nutrition and health profile of elderly females residing in old age homes in 4 major cities of Gujarat. Baseline data on basic Infrastructures and facilities available in 12 old age homes were collected. Baseline data on nutritional status, lifestyle, and general and mental health profile of 149 institutionalized elderly females aged above 60 years were also collected. The institutional profile revealed that old age homes of Ahmedabad and Baroda offered better facilities. Poor dietary and other facilities were offered by the old age homes in Rajkot. Only 7 homes provided less than three meals per day. Anaemia was prevalent in

more than 45% subjects. Dietary intake of protein, fibers, iron and B carotene was less than the RDA. Problems of the oral cavity, pain in joints, mobility, vision, neurological problem, sleep disturbance, constipation and etc., were prevalent among the subjects. GDI scores showed no significant difference between the age groups and inmates of different cities. But it showed a significant difference in MMSE and CIT scores. Location, environment activities and male inmates might have an influence on the health of the elderly.

Livia and Ines (2014) analysed the prevalence of depressive symptoms among institutionalized elderly individuals and to analyse factors associated with this condition in Brazil. This was a cross-sectional study involving 462 individuals aged 60 or older, residents in long-stay institutions in four Brazilian municipalities. The dependent variable was assessed using the 15-item Geriatric Depression Scale. Pearson's regression was used to evaluate associations with co-variables. Prevalence of depressive symptoms was 48.7%. The variables associated with depressive symptoms were: regular/bad/very bad self-rated health, comorbidities, hospitalizations and lack of friends in the institution. Five components accounted for 49.2% of the total variance of the sample: functioning, social support, sensory deficiency, and institutionalization and health conditions. In the factor analysis, functionality and social support were the components which explained a large part of the observed variance. A high prevalence of depressive symptoms, with significant variation in distribution, was observed.

Naveen et al (2014) assessed the geriatric problems among inmates of Old age homes in Hyderabad. Random sampling technique was adopted to select 50 subjects. The result shows the level of physiological problems of 50 inmates. Among them, 78% had mild physiological problems and 20% had moderate physiological problems. Level of psychological problems of 50 inmates was 22% had mild problems, 54% had moderate and 24% had severe psychological problems. The duration of stay in old age home had a significant association with physiological problems. The study revealed that the sex, educational status, marital status, income source, type of family, religion, duration of say and visitors have no significant association with geriatric problems of inmates.

Niebuur (2014) analysed the life satisfaction of elderly in Institutions in Dutch. The Interview was taken from 908 respondents, 655 of them lived in a

residential home and 253 lived in the somatic ward of a nursing home. The results revealed that the relationship between privacy and life satisfaction was significant and strongly positive. Institutionalized elderly who perceive the degree of privacy in the institution, score points higher than those who do not experience enough privacy in their living environment. Lonely inmates rate their life satisfaction 0.43 points lower than their inmates not suffering from loneliness. Nursing home residents' rate their satisfaction with life significantly lowers than the elderly in residential homes.

Rakesh and Sharika (2014) have described coping strategies adopted by the institutionalized and non-institutionalized elderly in Kathmandu, Nepal. The study was carried out among 132 old aged people of 60 years and above living in old age homes and home settings in Kathmandu. The coping strategies were found to be effective among non-institutionalized elderly and there was a significant difference between coping strategies of the elderly living in institutional and non-institutional settings. The psychosocial problems were dependent on educational status, monthly income and interpersonal relations in institutionalized early and with present job status, monthly income and type of family in non-institutionalized elderly. The elderly living in their own homes were able to cope with the psychosocial problems in an effective way. The study suggests the need for encouragement towards joint family norms in this changing context of the world. Older adults should be trained for activating and should be involved in the family activities and useful works rather than keeping them away.

Sireesha and Sivakumar (2014) have analysed psychiatric morbidity, quality of life and coping skills among elderly people living in old age homes and in the community of Hyderabad. It was a cross-sectional, comparative study, and 50 were selected by random sampling and assessed on GHQ, MMSE, MINI, PSLES, CCL, and SF-36. Results revealed that psychiatric morbidity was more in OAH (93%) than community (16%). Cognitive impairment was found in 20% of OAH inmates, 18% of the community. There were more of stressful life events in OAH (2.21) than community (1.1). Inmates of OAH used emotion-focused coping strategy, subjects of the community used emotion and problem-focused coping strategy. Medical morbidities were more in OAH (100%) than community (84%). Quality of life was better in the community than OAH. Most common medical morbidity was hypertension, diabetes and arthritis. Finally, it can conclude that Geriatric clinics can improve the health and

mental status of the elderly population by screening to detect the morbidities early and creating awareness in them.

Vanitha (2014) analysed Institutional care of the elderly in old age homes of Hassan City. Objectives of this study are a) to know the problems of the elders in OAHs, b) to understand the Institutional care given by the OAHs and c) to analyse the situation of physical and mental health of the elderly. Data were collected from 100 samples. The major problems observed were physical and mental disorders and adjustment problems with fellow inmates by taking care of almost all aspects of their life including proper diet, regular exercise, health check-ups, meditation and recreational activities. Old age home has a great responsibility in taking proper care of the elderly and the institutions under study deliver commendable services within the limitations.

Yadav Lalan (2014) conducted a study of old persons residing in an old age home of Delhi. The objectives of the study were a) to find out the facilities provided by the old age homes, b) to analyses the socio-economic background of the respondent, c) to find out the family relationship of the respondent and d) to analyse the reasons for shifting from home to the old age home. 40 inmates were interviewed by interview schedule, 16 males and 24 females. 52% of the elderly were in the age group of 71 to 80 years. Majority of inmates had estranged relations with their children. Majority of (60%) the respondents had been living for a total of five years. The most commonly stated reason by the respondents for shifting to an old age home was a conflict with their sons (40%). 30% had nobody to take care of them. Most of the women in old age homes spend their whole life doing household works and have no income for their livelihood.

Bhagat and Javali (2013) focused on the presence of depression in inmates of old age home and its impact on their perception towards the care given at their old age home. The main objectives of this study were to ascertain the presence of depression among inmates and to find out the correlation between depression and person perceptions regarding the care given in their old age home. 90 inmates participated from 2 old age homes in Karnataka. They were selected by random sampling technique. Medico psychological questionnaire for general neuroticism was administered to find out the depression scores and interview schedule is used to assess the perception. The result revealed that there was a significant correlation between

depression in inmates of old age home and their perception towards the care given at their old age home at 5% level of significance. The implication of this study was to develop insight and understanding among the caretakers of old age home that the depression has an influence on inmates' negative perception which keeps them unhappy at their stay.

Doshi and Yogesh (2013) analysed the mean difference between adult and aged in depression and psychological wellbeing. A total of 60 samples were taken out of which 30 were aged (60 years and above). The main objectives of the study were 1) To measure the depression among adult and aged; 2) To measure the psychological wellbeing among aged people and 3) to check co-relation between depression and psychological wellbeing. The research tool for depression, Beck Depression Inventory was used. For psychological wellbeing, Sudha Bhogle's psychological scale was used. Result reveals that there was a significant difference in depression and psychological wellbeing with respect to adult and aged.

Monihar (2013) investigated which was appropriate for the happiness of the elderly. The study was conducted in Kolkata, 100 elderly informants were selected from their family and 100 elderly from old age homes. It was concluded that 82% of the elderly were missing their grandchildren and family members. They were less interested to be associated with their fellow inmates due to differences. But the elderly people, who were at their own family, were mentally in a better position. The family network supports the psychological well-being of elderly people.

Patil (2013) analysed socio-demographic and health profile of inmates of old age homes in and around Belgaum city, Karnataka. Out of 73 elderly, 54 were female inmates and 19 were male inmates. It was observed that the majority of them were in the age group of 61-70 years and 56 belonged to the nuclear family. 47 inmates were admitted as there was nobody to take care of them. Common health problems observed were locomotive joint and muscle disorders (35.6%), hypertension (34.2%), diabetes mellitus (26.0%), respiratory disorders (23.3%) and hearing loss (21.9%). The majority of inmates were having haemoglobin level between 10-12g/dl (58.9%).

Ramesh (2013) analysed the health status of elderly living in old age homes in Karnataka. The major objectives of the study were 1) to understand the status of the

elderly population and health problems, 2) to study the health status of elderly population living in old age homes and 3) to analyse the quality of life affecting the overall health of elderly in old age homes. The sample consisted of 120 elderly who were living in 24 old age homes. It was found that most of the elderly were forced to stay in old age homes. 51.7 per cent of respondents were living in dormitory whereas only 9.1 % of the respondents were living in a single room or twin sharing basis. Regarding the drinking water facilities, 74% of the respondents depend on the public tap water. The major health problem as reported by the male elderly was BP/ sugar (43%) followed by joint pain 8%, for vision/ hearing problem 5% and others 17%. It was found that the majority of inmates (94%) prefer allopathic treatment followed by homoeopathic constituted 0.8%. Majority of homes (64%) did not have any nursing staff that largely affected the quality of healthcare in these homes. Majority of inmates were not aware of the health insurance policy (98.3 per cent). The study found that most of the inmates of the old age homes were economically dependent and less educated. The health conditions of the inmates were not satisfactory.

Ranjan et al (2013) described the prevalence of depression among elderly people living in old age home in the capital city of Kathmandu. The main objectives of the study were to assess depression among elderly residing in an old age home in Kathmandu, Nepal and its association with some of the socio-demographic variables. 150 elderly people residing in the 'Social Welfare Centre Elderly Home' were selected randomly. Geriatric depression scale [GDS] was applied in all the individuals to assess the prevalence and degree of depression. The study revealed that 47.33% of the population had depression. Among the depressed population, 70.42% had mild depression and 29.58% had severe depression. There was a significant association between the prevalence of depression and a history of physical illness. A depressive disorder is highly prevalent among the elderly population residing in the old age home in Kathmandu with a history of physical illness.

Reji and Sarvjeet (2013) have investigated the prevalence of common physical health problems among the elderly in selected old age homes of the cosmopolitan city of Pune. A total of 150 elderly were selected from 7 old age homes in Pune by multistage sampling method. The objective data was assessed by recording BC for hypertension, performing HP analysis, urine analysis, measuring BMI for obesity,

screening vision problem and hearing problems. The findings of the study revealed that 45% of the inmates were in the age group of 70 to 79 years. Women outnumbered men. Most of the elderly prefer to live in old age homes, 53% of the elderly being financially supported by family members and 25% have spent more than three years in the old age homes. The study also found a significant association of hypertension and diabetes with age, diet and exercise. In addition, a significant association was also observed between hypertension and diabetes mellitus.

Akshaya Kumar and Syamala (2012) conducted a study about living arrangement preferences and health of the Institutionalized elderly in Odisha. The main objectives of the study were to find out background characteristics, reasons for staying in old age homes, living arrangement preferences and the health of the institutionalized elderly in Odisha. The data was collected from three old age homes in Odisha covering 50 respondents. The study shows that the elderly residing in old age homes were poor, helpless, and destitute and the majority was from the vulnerable section of the society. Older- olds, widowed, economically dependent, childless and sick elderly were more vulnerable compared to others. Family conflicts, lack of money and ill health were the major reasons for the elderly to depend on various compulsions rather than by choice. The incidence of poor health and disability was higher among the institutionalized elderly. Overall the elders preferred to live with the family.

Anitha, Palani and Sathiyasekaran (2012) conducted a study to explore the health problems of elders in old age homes in Chennai City. Data on health problems were collected by clinical examination and available medical records. Result reveals that medical services were found available in all the homes. Only 3.3% of elders were clinically free from health problems and the remaining elders were suffering from one or more health problems. Major health problems of elders were cardiovascular diseases (42.8%), dental problems (37.6%) and visual problems (35.1%). This study shows that greater proportions of institutionalized elders were suffering from a wide range of morbidities.

Asadullah et al (2012) have studied the morbidity profile and quality of life of inmates in old age homes in Udupi district, Karnataka. The study was carried out to assess the socio-demographic profile, morbidity pattern and quality of life of inmates in old age home. Pre-structured questionnaire and WHOQOL scale were used for

assessing the quality of life. The study included 5 old age homes from Udupi district. 90 inmates participated in this study. Results revealed that the main age of inmates was found to be 76 to 86 years. Out of 90 inmates, 74% were female. The most prevalent morbidities were hypertension and diabetes with the distribution of 48% and 44% among males, 43% and 34% among females respectively. The respondents showed the highest quality of life score in the environmental domain and least score in social relationship domain. The study concluded that organizational care and support is essential for the health and wellbeing of the elderly. To improve the quality of life in elderly, emphasis should be given on the development of social relationships and self-belief restoration by counselling.

Heydari, Khani and Shahhosseini (2012) analysed the health-related quality of life of elderly people living in two settings; (i) Residents in a nursing home and (ii) Old age homes in a district of North Iran. The data were drawn from 220 elderly (60 years of age) sampled from both settings. The average scores for several domains including total physical health, total mental health and overall health were less than 50, which can be interpreted as a less desirable level of health-related quality of life in Iranian elderly people. Residents living at homes scored better in all domains of SF-36. Multiple regression analysis indicated that residency, marital status and education had a significant coefficient for total SF36 score. The health-related quality of life of elderly people in one city in Iran, particularly those in nursing homes, is inadequate. There is a need to design programs to increase elderly people's interaction with others and establish social networks for them and opined that these may enhance a sense of the positive quality of life among the elderly.

Marlene et al (2012) have investigated the images of ageing in institutionalized and non-institutionalized elderly people in Portugal. The aim of this study was to assess and compare images and stereotypes of ageing in institutionalized and non-institutionalized elderly people. A total of 120 elderly people aged between 65 and 99 years participated in this study. Statistically significant differences were found between institutionalized and non-institutionalized older adults. In the factor dependence, sadness and old-fashioned the institutionalized participants presented a higher number of negative images and stereotypes than the non-institutionalized participants, these differences were significant. In the maturity activity and effectivity

factor, there were also significant differences. The non-institutionalized participants present higher rates of positive images and stereotypes when compared to the institutionalized participants. The results suggested that institutionalized older adults presented more negative ageing images than non-institutionalized participants.

Nagaraj et al (2012) compared the psychiatric morbidity and quality of life of elderly people residing in two unique settings: community and old age homes. The elderly subjects, 50 each in both the groups, were selected by simple random sampling technique and assessed on Mini-Mental Status Examination (MMSE), Informant Questionnaire on Cognitive Decline in Elderly (IQCODE), Brief Psychiatric Rating Scale (BPRS) and Quality of life visual analogue scale. On comparison using suitable statistical analysis, there was no significant difference in the total scores on MMSE, IQCODE and quality of life scale across the groups. Depression was present in 22% of people in the community and 36% of old age home inmates. Psychosis was present in 26% of people in the community and 20% of old age home inmates. The psychiatric morbidity is high in elderly irrespective of the setting in which they live.

National Centre for the protection of older people (2012) conducted a study of older people's experiences of mistreatment and abuse in Dublin. The objectives are a) to examine the extent and impact of abuse on older people, b) to examine the decision making pathways and forms of action taken in response to the abuse, c) to explore the coping strategies adopted by older people to deal with the abuse and d) to identify the support needs of older people who have experienced abuse. Only older people who met the inclusion criteria were approached to take part in the study. The findings indicated that most of them experience more than one type of abuse and there was more than one abuser. Some were physically assaulted and restrained, having money stolen from them, belonging were damaged and misused, and some were verbally abused and were denied access to grandchildren.

National Institute of Ageing, (2012) supports research on the health, social support and economic security of India's ageing population. The LASI [Longitudinal Ageing Study in India] surveyed a sample of 1700 Indians aged 45 and older in four states [Karnataka, Kerala, Punjab and Rajasthan], chosen to reflect the Nation's regional, cultural and socio-economic variation. 13% of older Indians sampled have some type of disability that affects at least one activity of daily living. More than one

quarter was underweight and nearly one third was undiagnosed hypertension. Overall, they find twice the risk of cardiac conditions for those in the oldest age groups, those who have higher education level and those who are overweight compared with their respective counterparts. The researchers suggest that, the health care system should be strengthened and that the negative diet and sedentary lifestyle associated with urban living and economic development should be addressed.

Pradeep Kumar (2012) conducted a study about mental and physical morbidity in old age homes of Lucknow. This study assessed mental health problems and associated morbidity amongst inhabitant of old age homes in Lucknow. Survey Psychiatric Assessment schedule, Mini-mental status examination, Mood disorder questionnaire, and schedule for clinical assessment of Neuropsychiatric disorder based clinical interviews were carried out. More than half of the inhabitants of old age homes were suffering from one or other mental health problems, depression being the most common one. The inhabitants suffering from psychiatric illnesses had one or more associated physical morbidity. Findings reveal a higher prevalence of mental health morbidity compared to the community prevalence.

Abhay et al (2011) stated the assessment of Quality of Life among rural and urban elderly population of Wardha district, Maharashtra. The study was carried out with twofold objectives to assess the differences of quality of life between rural and urban elderly population and to find out the association between the socio-demographic profile and quality of life of the elderly population. The community-based cross-sectional study was conducted on 800 elderly subjects selected from urban (n=400) and rural (n=400) using the multistage simple random technique. The WHOQOL-Bref was used to assess the quality of life. The study showed that the elders living in the urban community reported a significantly lower level of quality of life in the domains of physical and psychological than the rural elderly population. The rural elderly population reported a significantly lower level of quality of life in the domain of social relationships and environmental than the urban population. The difference between the quality of life in the rural and urban elderly population is due to the difference in the socio-demographic factors, social resource, lifestyle behaviours and income adequacy.

Anil Kumar (2011) examined psychiatric morbidity among elderly people living in old age homes and in the community. The study sample was selected from two

largest old age homes in urban Mysore. Subjects were selected by simple random sampling technique. The total sample size was 100, of whom 50 resided in the community and 50 stayed in homes for the aged. Out of 50 in community, 22% were found to have mild to moderate depression as compared to 36% of old age homes. People in old age homes had a significantly better perception of social support and felt better than those living with their children's family. Finally, the psychiatric morbidity is high in elderly irrespective of the setting in which they live. Education and living with a spouse are the factors associated with better psychological health.

Aruna et al (2011) analysed the feeling of institutionalized elderly people. A study was conducted to understand the feeling of the elderly residing in the old age homes and within the family set up in Jammu. The sample of 30 elderly women from the old age home and 30 elderly women from households were selected using a purposive sampling technique. Non-working status of these women and above 60 years of age were criteria for sample selection. Results of the study revealed that most of the elderly felt the attitude of the younger generation towards them was unsatisfactory. The research reported that life satisfaction was strongly related to socio-demographic and psycho-social variables. Out of 30 women living with their families, 43.3% had an interest in reading religious books, magazines, and watching television. In the institutions, 33% of the elderly women stated that listening to music relaxed them and helped them to forget their tension, worries and stress. It could be concluded that the general feeling of the elderly women living in the families was better than those in the institutions.

Simone et al (2011) stated the quality of life of elderly patients assisted by a Homecare program. Analytical cross-sectional study was followed. Elderly patients of a home care program were assessed regarding socio-demographic, clinical, functional data and quality of life by the WHOQOL-Bref. The sample comprised 23 elderly patients, mostly female (69.6%), with a mean age of 84.22± 7.89 years. The variables that presented the significant association with the WHOQOL-Bref domains were; depressive symptoms, number of illnesses and functional capacity; with the physical domain; age, functional capacity, number of drugs and depressive symptoms. Factors that negatively influence the QOL of elderly patient's in-home care are: young elderly, high-intensity pain complaint, poly-pharmacotherapy, a high number of illnesses,

presence of depressive symptoms and other psychiatric affections, and functional deficit.

Kashyap (2011) conducted a study to appraise postural stress among inmates of old age homes in Kumaon region of Uttarakhand state of India. Inhabitants of Geeta Kutir, an old age home, 20% of elderly people were selected (n=60). The purposive sampling design was to select the participants for the study. The goniometer was used for the postural stress measurements. The findings depicted that using an electric switchboard was most stressful in shoulder external rotation. It is recommended that electric switchboards and other articles should be placed according to the principles of ergonomic. It can be concluded that neglect of ergonomic principles brings inefficiency and pain to the elderly people in the workplace. It is observed that the elderly people faced difficulties to utilize electric switchboard, picking article from upper shelve of cupboard and using lower shelves. Along with gerontology, it would help to reduce the effects of age-related impairments with technological devices thus, improving the home environment. This research, therefore, highlights the essential key factors that should be considered as the main criteria when designing the old age homes.

Kirtana (2011) reported a comparative study of nutritional status of the elderly population living in the home for aged and those living in the community in the city of Mangalore. Subjects aged over 60 years were included in this study. Nutritional status was evaluated by anthropometric measurements to calculate the Body Mass Index and triceps skin found thickness and by data collected through the Mini nutritional assessment. A total of 210 subjects participated in this study. Out of them, 108 inmates of old age homes and 102 people who were residing at their houses. The results showed that the elderly at home had higher BMI and higher MNA scores compared to those living in old age homes. The MNA result revealed that 19.4% of subjects were malnourished and 57.4% were at risk of malnutrition among the old age home residence. The prevalence of malnutrition by MNA was 2% those at risk of malnutrition were 14.7% in free-living elderly. The results of this study show a high risk of malnutrition in the old age home residence and confirm the need for increased surveillance of nutritional status among residents of old age homes.

Age UK (2011) reported [British Institute of Human Rights] about older people and human rights in UK. The major purpose of this report is a) to provide practical information for provisional and b) to provide a summary of existing evidence of human rights issues affecting older people in UK. The project has delivered three human rights training sessions for staff and volunteers and five training session for each of the older people's groups. The groups of older people have also identified and developed small local advocacy projects. The report found that older people are provided with clear and accurate information about human rights, they can see a great deal of potential.

Nekar and Mahesh (2011) worked on quality of life among the old aged in Karnataka. They aimed to determine the health-related problems among the elderly; to determine the different domains of quality of life affected and restricted activity days in the elderly population. The method was a community-based, cross-sectional study on 200 geriatric subjects (greater than 60 years) by a simple random sampling method. WHOQOL-Bref scale was used to assess the quality of life. Results showed that 72.5% were in the age group of 61 to 70 years, 52% were males and 50% belonged to poor socio-economic status and 94% were literates. Vision problems (64%), arthritis (55.5%), hypertension (47.5%), diabetes (38.5%) constituted the bulk of morbidity. Physical domain was affected significantly in quality of life. Geriatric clinics can improve the health status of the elderly population by screening to detect the morbidities early and creating some awareness in them.

Bockerman et al (2011) examined institutionalization and quality of life for elderly people in Finland. In this study, a population-based prospective survey involving 366 men and 409 women aged 60 years and over were conducted. Age-adjusted and multivariate Cox proportional hazard models were used to examine the predictive association of urge incontinence, neurological, cardiovascular, musculoskeletal, and other chronic diseases, activities of daily living disability, and depressive symptoms with institutionalization separately in men and women. Those living at home are on average happier than those who do not, given the household and education variables present in the specification. This is the result that seems to be on policy-makers minds, and would as such give support to policies that decrease the incidence of institutional living. When controlling for health status, demographics and

income, they found that individuals living in old age homes actually report higher levels of happiness than those living at home.

Ehud, Sara and Abraham (2011) examined sheltered housing and community-dwelling, quality of life and ageism among elderly people. The sample included 126 volunteers, aged between 64 and 94 years, who live in private sheltered housing (n=32) and in the community (n=94). The participants completed the Fraboni scale of ageism, and a QOL inventory (SF-36). People, and men in particular, who live in sheltered housing, reported more intergenerational ageist attitudes than men and women who live in the community. Inmates in sheltered housing expressed lower evaluations of their mental health, but higher evaluations on 'social functioning' (QOL Scales). Women from sheltered housing reported better mental health than men. Gender and some QOL scales were associated with higher ageism. Differences in ageist attitudes between both dwelling places can be interpreted according to social identity theory, which refers to the impact of the in-group on social attitudes. Differences in QOL can be understood by the accessibility of social activities in private sheltered housing. Gender differences in ageism and QOL can be explained by women's better social adjustment.

Prabhavathy (2011) examined Nutritional profile of institutionalized elderly women in Chennai. The study focused on understanding the background information and lifestyle pattern of 300 elderly women residing in ten old age homes i.e. five paid and five unpaid categories and to assess their nutritional status. 150 samples from paid homes and 150 samples from unpaid homes were interviewed based on their willingness and co-operation. The maximum age of the elderly studied was between 70 to 79 years. Majority of them were not earning, but their relatives/friends financially supported them. More than 50% of the elders did not have anybody to take care of their needs. Out of 300, 21% disagreed with son/daughter/son-in-law/daughter-in-law and therefore, opted for old age homes. 12% in unpaid homes and 13% in paid homes chose to be independent without being a burden to their children. Both paid and unpaid elders were satisfied with their basic needs, only 2% in paid homes and 6% in unpaid homes were satisfied with psychological needs and only 7% of unpaid elders were satisfied with financial needs.

Rekha and Vijaya (2011) in their study 'Dental prosthetic status and prosthetic need of the institutionalized elderly living in geriatric homes in Mangalore' reported that a high unmet need for prosthetic care existed among the institutionalized elderly. To promote oral health among the elderly, there was a need to know the prosthetic status and prosthetic need. The inmates of old age homes in Mangalore were interviewed. 133 subjects aged 60 years and above, were examined (54.1% males and 45.1% females). 88% of those examined were fully edentulous and only 12% had complete dentures. None of the study subjects had partial dentures.

Shubha (2011) conducted a study about elder abuse in India. The aim of the study was to (1) define and identify the symptoms of elder abuse (2) to create awareness about its existence to the Primary Health Care workers and (3) to develop a strategy for its prevention. Focus group discussions were held to gather data from the participants of the study. The samples were taken from urban society residing in Delhi. Two major groups were addressed, the older persons and the Primary Health Care workers who interact with those persons when they approach as patience. Lack of accommodation was also a problem identified by the older persons who had houses of their own and were not staying in apartments. Health problems surfaced as being the most common problems faced by the older persons in the mixed group both in the lower and upper middle strata of society followed by financial problems. Economic hardships became very prominent in the women of the lower socio-economic group while the highest socio-economic category put loneliness as the primary problem affecting the old persons today.

Vishal et al (2011) described the depression among aged in Surat city. A cross-sectional study was conducted among elderly belonging to different socio-economic and varying demographic groups of Surat city. A total of 105 elderly were interviewed, comprising of 35 people each from the elderly living in the old age homes, those living in the affluent areas and those living in the slums of Surat city. A probability sample was obtained by approaching all the subjects in a consecutive manner. The majority (80.8%) of the subjects was in the age range of 64-76 years. Out of 105 samples, 43 were males and 62 were females. It was observed that a lesser per cent of illiterates (26.6%) reported depression compared to literates (44%). The prevalence of depression was moderately high (39%) among the elderly in old age

home. The severely depressed and those who require institutional treatment were more in old age homes (25.7%). Among those staying single 74.4% reported of depression.

Lai et al (2010) examined health-related quality of life and health utility for the institutional elderly in Taiwan. 465 elderly persons living in long-term care institutions in Taiwan were interviewed using Taiwan's abbreviated version of the world health organization quality of life (WHOQOL-Bref), Rating scale (RS) and the Time-Trade-Off (TTO) utility measurement. Educational level, number of chronic diseases, physical performance, and number of caregivers had significant ($p<0.05$) impacts on the domain scores of the WHOQOL-Bref. The physical performance had the strongest impact on the physical domain and accounted for significant percentages of the variance on the other three domains. The validity of TTO utility for studying the institutionalized elderly needs further evaluation.

Kashyap and Sharma (2010) analysed the ergonomic assessment of old age homes and related health hazards on elderly people. The purposive random sampling was adapted to select districts and blocks. Sixty elderly people from four old age homes were selected randomly for the study. The study was conducted in Kumaon and Garhwal regions of Uttarakhand. Descriptive cum experimental research design was adopted. The data were analysed using both descriptive and relational statistics. The finding showed that the majority of elderly people belonged to 60-80 years age group and the mean age was 72.5 years. Unmarried female and widows dramatically outnumbered male widowers. The females had better smell and hearing capabilities than males. However, the general health status of males was better than females.

Nhamo (2010) conducted a study on the role of old age institutions in the care of elderly people in the context of hyperinflation in urban used qualitative approach and ethnographic method for data collection. This research used a non-random sampling method called snowballing. The interview and observation were conducted in three categories. At the time of the study, the old age home only had 26 residents and was ironically not operating in full capacity. The elderly in institutions grew vegetables which would, in turn, complement their diets. Another important issue which was established from the study was the relationship between the government, the community and the institution. This relationship was cyclical in nature. The hyperinflation played a pivotal role in compromising the quality of life of many elderly

people. From the interviews conducted with the residents, there was a lot of appreciation for the fact that their quality of life had improved.

Elisabeth, Kerstin, and Gunnar (2010) examined the effects of physical training on physical performance in institutionalized elderly patients (70+) with multiple diagnoses in Sweden. A total of 16 randomized controlled trials were included in the review. Six studies scored as high quality, eight as moderate and two as low. There was large heterogeneity in the studies concerning sample size, types of interventions and types of assessments. There is strong evidence for a positive effect of physical training on muscle strength and mobility; moderate evidence for an effect on a range of motion; and contradictory evidence regarding gait, activities of daily living, balance and endurance.

Ajay et al (2010) focused on the study of morbidity pattern in inmates of old age homes in the urban area of central India. The study was conducted in Nagpur. A cross-sectional study was carried out among all 221 inmates of three old age homes. Majority of inmates (62) were in the age group of 80 years and above. 164 belonged to Hindu religion. 147 were widow or widowers. 179 were dependent economically. For 77 inmates loneliness was the reason for admission. The most common morbidities found were anaemia in 145, arthritis in 87, hypertension in 83, cataract in 69, and acid peptic disease in 47. Other morbidities found were impaired hearing in 38, bronchial asthma in 31, and diabetes mellitus in 28 inmates. The results of the study showed that the major portion of the elderly was dependent economically, neglected, lived alone and suffering from various health problems. Health education regarding stress management exercises, yoga, etc., should be given to inmates of home for aged.

Khow, Teo and Rashid (2010) examined the cognitive impairment and depression among residents of an elderly care home in Penang, Malaysia. The study was aimed to determine the prevalence of dementia and depression and their associated risk factors among residents of a privately run old age home in Penang. The baseline demographic data, elderly cognitive assessment questionnaire and Geriatric Depression Scale was used to screen for cognitive impairment and depression. Out of 190 eligible participants, 155 responded. The prevalence of dementia was 12.3%. Age, illiteracy (5.57), unemployment (9.33) and being functionally dependent on the activities of daily living (4.52) were significantly associated with cognitive impairment. History of

unemployment (9.88) and being illiterate (5.22) were found to be significant predictor variables for cognitive impairment. The prevalence of depression was 20.6%. Being functionally dependent on the activities of daily living (2.67) was found to be significantly associated with depression. Being functionally dependent (2.87) was also found to be a significant predator variable for depression.

Kashyap (2010) stated designing criteria for storage spaces in old age homes in India. The study was conducted in two regions of Uttarakhand state of India with an objective of evaluating the dimensions of storage facilities in old age home and to determine whether these types of storage facilities are well designed and promote good posture by taking in to account the dimensions of elderly people. The purposive sampling design was adopted to select the samples. Anthropometrics data were collected from twenty per cent of the total from one old age home. The dimensions were measured for three different types of storage facilities prevalent in old age homes. Finally, the Anthropometric measures of the elderly and the storage dimensions were compared in order to identify any incompatibility between them. Elderly females had problems in reaching the top shelf of the cupboard and both the sexes needed redesigning of lower shelves of storage. Finding revealed that the attention of all architects, engineers, residential designers, builders, developers and agencies who are engaged in designing and building houses intended to be occupied by the elderly.

Mariana Ayres Vilhena (2010) in her article 'Quality of life of Institutionalized elderly in Brazil' reported that as the population increases, the search for institutions for the elderly also increases. Institutionalized seniors of the city of Avare participated in the research of three institutions, forming three groups. The questionnaire used was the SF 36, to evaluate the quality of life. The domain-general of health obtained similar values for the three long term care institutions, however with a low score (22). The score emotional aspect was significantly different from the other long term care ($P< 0.01$). The results of the point that the QOL of institutionalized elderly of the city of Avare was low, showing the importance of the evaluation of QOL in those institutions

Ioanna and Dimitra (2010) from University of Athens analysed the differences of quality of life and loneliness between elderly people. The sample selection was purposive method and data were collected from 180 persons aged 60-93

years old from Greece. Quality of life was estimated through the quality of life index, loneliness through the UCLA loneliness scale, and demographic characteristics with a questionnaire. For the quality of life, males had higher scores than females, older than oldest and married than divorced/widows/widowers respectively. Further, divorced had a better quality of life than widows/widowers, but with no significance. Concerning loneliness, males scored lower than females, older than oldest and married than divorced/widows/widowers respectively. Divorced had lower loneliness than widowers, but with no significance. In conclusion, elderly perceptions about their conditions of living guide practitioners to find out the real deficits on elder's daily living and finally form suitable rehabilitation programmes.

Hsiao-Ting Chang et al (2010) stated the institutionalized senior veterans' quality of life in Taiwan. This study aimed to explore the quality of life and related factors of VH-dwelling senior veterans in Taiwan. Chronic conditions and socio-demographic characteristics of 260 male VH residents were recorded. The brief form of the World health organization's quality of life questionnaire (WHO QOL) and Barthel index were used. Participants scored low in all concepts of SF-36. Although these residents rated the social support of their children, relatives, friends, social and medical staff as low, they gave high satisfaction ratings to their social supports. In general, institutionalized senior veterans' quality of life was lower than Taiwanese male residents. Helping senior veterans to effectively improve their subjective mental health and social support, and controlling chronic disease appears to be critical to their quality of life.

Suhara Beevi (2010) explained the profile of elderly women living in old age home in Kerala. The objectives of the study were a) to find out the socio-economic characteristics of the women inmates and b) to study the facilities provided to the inmates. The study was conducted in two districts Alappuzha and Kottayam of Kerala. The sample size was 210 and was taken from 30 old age homes. It was analysed that majority of them were widows (49.5%), One-third of them were illiterates (27.6%), majority of them were Christians (76.2%), 50.5% were self-employed, 65.7% did not have children, 48.1% did not have anybody to take care, 81.9% felt isolation and loneliness. Majority of them had the problem of sleeplessness and stated about bad health. Majority of them, live in dormitory system.

Dechamps et al (2009) published an article 'Health-related quality of life in frail Institutionalized elderly: effects of a cognition- action intervention and Tai chi'. A new intervention based approach using familiarity based movements and non-judgmental approach of 'cognition-action' was proposed and was tested with Tai chi on health-related quality of life in frail institutionalized elderly. Aged from 65 to 94, 52 participants took part in a 2-week programme. Changes in Mini-mental state score fall efficacy scale and exercise self-efficacy were explored. Adapted CA programs and Taichi were both efficient in improving HRQOL of frail elderly.

Ceremnych and Mereckas (2009) examined the subjective evaluation of ageing among older women living in Homes for the elderly in Lithuania. They assessed their own ageing by means of special Attitudes to the Ageing Questionnaire (AAQ) developed by World Health Organization on quality of life of older people group. The participants were older women (88) living in Vilnius homes for the elderly, aged from 60 to 94 years. Comparisons of mean scores of AAQ items among women aged 60-70 and 80-94 years old showed that both groups of respondents rated their psycho-social losses in a similar manner. Respondents in the age group 80-94 years had statistically lower scores of AAQ physical scale scores. This study using subjectively rating scales and content analysis of responses have confirmed statistically significant differences in views towards ageing among older women dwelling in homes for the elderly mostly in views on physical signs of ageing. As evidence in the results section, the AAQ instruments scores were found to be significantly correlated with other health status measures.

Vishnu et al (2009) examined depression among the elderly, living in old age homes and in other domiciles in Trivandrum corporation area. They devised a descriptive study among elderly population aged above 69 years living in old age homes and in the community. 50 cases from each group were interviewed using a structured questionnaire using GDS (Geriatric Depression Scale) which is widely accepted for assessing the depression among the elderly. Results revealed that depression was found to be more in inmates of old age homes. Among the 50 cases in old age homes, 4 of them were having mild depression, 28 were having moderate depression and 18 were having severe depression. Among the 50 cases studied from the community, 34 were having mild depression, 14 were having moderate depression and

2 were having severe depression. On sex-wise analysis, depression was found to be more among females. Occupation wise and age-wise analysis proved to be insignificant. They concluded that depression was more among the inmates of old age homes.

Anitha Rani, Palani and Sathyasekaran (2009) in their article 'Abuse of elderly in old age homes-A study in Chennai' stated that elder abuse is a complex phenomenon. From 9 old age homes, 210 elderly were selected by simple random sampling technique. Data was collected by interviewing the selected participants. The elders in this study were mostly in the age group of 60-69 years (38.1%) and most of them were females (62.9%). The prevalence of physical abuse of elders in the old age home was 1.5%, psychological abuse was 11.4% and financial abuse was 0.5%. The overall prevalence of any one form of elder abuse in old age homes was 11.4%. It was observed in the report that institutionalized elders were abused and were facing hardships. The need for orientation of caretakers in the old age homes to provide appropriate care for elders was strongly recommended.

Anise, Catherine and Elsie (2009) conducted a study about elderly Chinese in Hong Kong. This study examined psychosocial factors associated with the acceptance of long-term placement in old age homes (OAHs) among 185 elderly Chinese in Hong Kong. Participants were recruited from local community centres for elderly people and were individually interviewed on their willingness to enter OAHs, attitudes towards OAHs, perceived mental and physical health status, and beliefs about filial piety and independence. Results showed that only 20% of the participants indicated their willingness to enter OAHs in the coming 6 months. Among depicted services and facilities in OAHs, participants rated the quality of OAH staff as the most important, whereas the choice of food and mealtimes were viewed as the least important.

Kanchan Bharati (2009) in his article 'Institutional care of elderly: A study of elderly living in old age homes of Hyderabad' reported that the study was conducted on elderly people living in old age homes of the twin cities of Secunderabad and Hyderabad in Andhra Pradesh. From 14 old age homes, 70 elderly people were randomly selected. In the study, more than 50 respondents were staying with the children/kin, prior to shifting to their respective old age homes. Less than 50% of

inmates said to be economically secure as they are receiving pensions and are economically independent. On part of various old age homes, it can be stated that though all old age home provides food, shelter and care to the elderly, it was found that these homes differ from each other in many ways. They represent homes of different class and nature, some of them providing elderly better care with better-required facilities whereas others are giving them just the needed support.

Mercy, Linu and Nandakumar (2009) in their article 'Comparative study on Stress Coping Strategies and Quality of Life of institutionalized and non-institutionalized elderly in Kottayam District, Kerala' stated that the survey used different tools such as socio-demographic proforma for institutionalized and non-institutionalized elderly, Stress rating scale, a coping inventory and WHOQOL -Bref scale. The total mean scores were higher among the non-institutionalized elderly compared to the institutionalized elderly. There was a significant difference between stress and quality of life of institutionalized and non-institutionalized elderly. Institutionalized elderly experienced high stress and low quality of life compared to the non-institutionalized elderly. The results indicate that elderly people need special attention as a special concern group. The study concludes that there was much scope to reduce the physical and psychological problems and improve the quality of life of the elderly by providing health care services based on the needs of the elderly.

Demiris and Hensel (2009) explained about 'smart homes' for patients at the end of life. They described the existing smart homes applications and discuss their potentials of home hospice patients and their families. The technological components serve can be classified into (i) Functional monitoring, safety monitoring, physiological monitoring, and cognitive support, security monitoring and social interaction. The majority of projects (71%) include technologies for functional monitoring, 67% had some type of safety monitoring feature. 47% had a physiological monitoring component and 43% had a cognitive support component. Finally, 19% of projects monitored security with security alarm systems and 19% of all projects utilized components that targeted social interaction such as smartphones and video conferencing features. As people approach the end of their life, such settings may have the potential to support the quality of life.

Helena et al (2009) in their article 'Old Aged Quality of Life: Brazil-India a cross-cultural perspective' explained the self-evaluated quality of life of old aged. In Brazil, the low-income population was always lower than the self-evaluated quality of life found in India. Indian old aged self-evaluation of quality of life showed to be always higher than the Brazilian old aged. In this co-relational descriptive research, old aged answered a WHOQOL questionnaire. In general, the Indian aged quality of life finding was higher than that of Brazil's low income old aged. This research confirmed the inference of social adjustment influencing hopes and expectation in quality of life. It also informed that Brazil's old aged quality of life concerning death and dying plus future and present activities were lower than Indians. As both samples were composed of low-income old aged, observed quality of life was also Low.

Robert and Richard (2009) stated the Quality of life in the elderly: comparison between nursing home and community residents. They interviewed 47 pairs of age and sex-matched nursing home and community persons. Housing, finances, health, and interpersonal relationships were associated with global quality of life for nursing home residents; for community participants, health, disability, finances, anxiety, and interpersonal relationships were associated with quality of life. Results suggest that health care providers cannot assume that their older nursing home residents perceive their quality of life to be worse than other elderly persons and that some people report that nursing homes improve their quality of life.

Bodur and Dayanir Cingil (2009) used the WHOQOL-Bref Scale to evaluate the quality of life among Turkish elders in different residential environments. Participants were 60 years old and older. The sample included 37 people who were living in a public assisted-living facility and 37 elderly people living in their own homes. The scores for elderly females staying in the assisted living facility were lower compared to the scores of males. The results suggest that social and environmental domains of life quality are low in elderly assisted living facilities. Social activities should be diversified for elderly people staying in assisted living facilities to improve social relationships. Physical and psychological health of females in assisted living facilities should be comprehensively supported by professionals. Alternatively, elderly people may be professionally supported to live in their own homes.

Oksoo et al (2009) investigated to describe loneliness, depression, and health status in Korean and Japanese institutionalized elderly and explore differences between the countries. Also, this study determined the predictors of depression in each group. Elderly subjects, aged 65–98 (n = 184), were recruited from private nursing homes in Korea and Japan. Subjects were interviewed on health status, loneliness, and depression. Korean subjects had higher loneliness scores than Japanese. More Korean elderly had depressive symptoms than the Japanese elderly. The mean GDS score of Korean elderly was 8.07 and that of Japanese elderly was 5.21. Korean elderly had less physical function and perceived their general health to be poor. Loneliness and perception of general health were significant predictors of depression in Korean and Japanese subjects. It is necessary to assess the levels of loneliness and depression of institutionalized Korean elderly and pursue an intervention to reduce these problems.

Habjanic (2009) conducted a study about 'Quality of Institutional elderly care in Slovenia'. The purpose of this study is the self-evaluation of nursing staff members. A questionnaire measuring five instruments is being used; four instruments measure the quality of nursing care and fifth instrument measures staff well-being. Findings stated that nursing home facilities and their staff should concern about hygiene, friendliness, conversation, company, nutrition and dwelling environment. Neglect and poor psychosocial support may also result in a poor quality of Institutional elderly care. Nursing staff members were not satisfied with working conditions and reported that they suffer from physical and mental fatigue because they were overworked. Nursing home residences in Slovenia are behind standards, apartments and rooms are small, more bedded without private or ergonomically adjusted bathrooms and unsuitable furniture being poorly arranged.

Beevi Suhara (2008) examined the morbidity status of the elderly women in institutions and non-institutions in Kerala. The study was conducted in two districts of Alappuzha and Kottayam in Kerala state. The sample size was 210 females from institutions and 216 from non-institutions. Random sampling method was used. Majority of the respondents in the non-institutions and institutions were self-employed and remaining had no employment. Half of the inmates were from above poverty line economic status. The percentage of vision impairment was more in the institution; many of them wanted to get the surgery for regaining the eyesight but were unable on

account of lack of assistance and resources. Among the common diseases and impairments; vision impairments, chronic asthma, diabetes and hypertension were more prevalent in the respondents and gastrointestinal disease and arthritis were more common among the inmates in the old age homes.

De Greef and Scherder (2008) in their article 'Frail Institutionalized Older persons: A comprehensive review on Physical exercise, Physical fitness, Activities of Daily living and quality of life in Netherland' explained the importance of physical exercise in old age. They reviewed 27 studies on older people in long-term care facilities and nursing homes. Their ultimate goal was to propose criteria for an evidence-based exercise protocol aimed at improving physical fitness, the activity of daily living performance and quality of life of frail institutionalized older people. The study concluded that there was firm evidence for training effects on physical fitness and quality of life.

Bharati Bhosale and Rohini Devi (2008) examined the health status of institutionalized elderly in Maharashtra state. In 19 old age homes, 500 institutionalized elderly were selected from the regions of Marathwada (Maharashtra state). These subjects were interviewed individually to elicit information on commonly prevalent health problems. Health status of the institutionalized elderly was assessed in the investigation. Majority of the selected elderly complained of impairment in vision (61.6%) followed by arthritis (47%), loss of memory (46.4%), insomnia (42.6%), headache (39.4%) and impaired hearing (38.4%). It can be concluded that majority of the elderly were suffering from different health problems. Prevalence of health problems was significantly high in elderly women as compared to men. Prevalence of health problems increased with the advancement in age.

Jyotsana and Jamuna (2008) studied the interpersonal relationships of the elderly in selected old age homes in urban India. The study focused on selected 'pay and stay' homes in the four cities of Hyderabad, Bengaluru, Chennai and Thiruvananthapuram. Personal interviews were conducted with 150 seniors to understand the relocation experience, the extent and nature of self-reported social networks, and evaluation by seniors of this late-life arrangement. Majority of respondents were females (65%). More than half of the respondents (58%) reported being currently widowed. Results show that childlessness and strained intergenerational

relationships were important considerations in the decision to relocate. Majority of the seniors had never visualized that they would be spending their autumn years away from family. Occupants frequently imagined their living space as their 'home'. Living amidst non-family members, the reported network sizes were small. The absences of family members were frequently cited as a source of dissatisfaction when evaluating these homes.

Esther Iecovich (2008) published an article about religiousness and subjective well-being among Jewish female residents of old age homes in Israel. The study explored the prevalence of religiousness among Jewish female residing in old age homes in Israel and its impact on their subjective well-being. The sample included 464 respondents residing in 48 old age homes. Religiousness was measured through self-rated religiousness and religious faith scales. Subjective wellbeing was measured by the PGC (Philadelphia geriatric centre). The findings revealed that the majority of the elderly define themselves as traditional, orthodox or ultra-orthodox. Multiple regression analysis revealed that religiousness did not affect the residents' subjective well-being.

Renu, Satwanti and Kapoor (2008) analysed the Environmental influence and Health status of elderly in Delhi. The study was conducted in order to explore and compare the health status of the elderly living in two different environmental conditions. A total number of 259 samples were taken. This included 120 elderly females from six old age homes and 139 elderly females from families. Nutritional status was studied using WHOBMI guidelines. The subjects staying in the old age homes had more regular diet, periodic medical health check-ups and a higher exercise level than their family living counterparts. The females in the old age homes were found to have lower body weight. Significant differences were found in weight, heart rate, blood pressure and BMI between most of the age groups of old age homes and females living with families. Percentage of overweight/obesity was found to be relatively higher among females living in families as compared to those living in old age homes. The nutritional status ($p<0.05$) were found to be significantly influenced by the environmental setup.

Shewanti (2008) in her study highlighted the 'Extent of Infrastructure' facilities available in Old age homes of Uttarakhand. The purposive random sampling was chosen for selection of area and samples. Descriptive data were collected from

randomly selected four old age homes; 15 elderly people selected from each old age homes. Thus, the total sample size was 60 elders in the selected four old age homes. The spread of male and females were 26 and 34 respectively. The infrastructural facilities in the old age homes were quantified by assigning scores for 'Yes' statements 1 and for 'No' statements 0. Using the total score, the percentage was computed. The scores were highest in III old age home which showed that the infrastructural facilities were superior followed by I old age homes, while lowest facilities were available in II old age homes as it was free of cost, The management and ensuring good service provider can be affected by inadequate staff members, infrastructural facilities and funds. However, based on responses obtained from the elderly people, the satisfaction level is poor, confirming that the facilities provided below bar services.

Sushma Goel and Mayanka Gupta (2008) conducted a study about the quality of life of institutionalized elderly in the national capital of Delhi. Four old age homes were selected and 60 samples were interviewed. The findings revealed that visual impairment was most prevalent among the elderly. The food menu was fixed and served at fixed intervals. In the case of inter-meal requirements, individuals had to make arrangements themselves. The analysis showed that all the necessary facilities were provided at OAHs, though they were not up to the mark due to which the residents felt unhappy. The data suggests that the residents of OAHs had either poor or moderate quality of life index. Only 3.3% of the respondents in free OAHs and 10% in paid homes had a good quality of life index.

Megha and Sarita (2008) analysed the quality of life of elderly women in old age homes and community in Delhi. A total sample of 50 elderly women were selected, 25 from the 2 OAHs and other 25 from the OP department of physical medicine and rehabilitation of the hospital. The results indicated that aged women who suffered from osteoarthritis had to spend much of their time indoors. If they went outside, they had to be either assisted by their relatives or maidservants in old age homes. Respondents in OAHs were in the habit of doing their work in spite of having pain and trouble. Of those in old age homes, 20% of the respondents always felt if they died it would be good for others as compared to 4% in the families, who felt this way. The quality of life was found to be better among the people living in families as compared to those staying in old age homes. The quality of life was specifically better

from psychological and social aspects. Regarding physical aspects, it was observed that respondents from families had higher severity. Families are still a better option for older persons because living in families and participating in family matters boost up their will power and confidence.

Shivani Rawat (2008) in her study 'Quality of Life and Life Satisfaction among Institutionalized elderly in the Era of Globalization: A sociological study – Hyderabad' reported that increasing number and proportion of elderly have a direct impact on the demand for health services, pension and social security payments. The aged feel lonely, dependent and marginalized. The life of senior citizens becomes more difficult when problems related to fulfilment of basic requirements such as social relations; personal care, nutrition and accommodation are added to old age health problems. The study also intended to understand the aims and aspirations of the elderly besides institutional services provided to these vulnerable sections of the society.

Pereira and Santos (2008) examine the quality of life of aged people living in homes for the aged in Portugal. It is a descriptive cross-sectional study. The sample consisted of 93 aged people divided among 4 institutions in the municipality of Portugal. The purpose of this study was to investigate the quality of life of the sample and the factors affecting it and identify the degree of dependence in basic daily living activities. The data was collected using the following tools: a) Bio relational questionnaire, b) quality of life evaluation scale and c) the Katz Index. In terms of the quality of life of the institutionalized aged people, 51.6 per cent include themselves in the group with quality of life and it was observed that there was a positive correlation between the Katz Index and the quality of life index regarding gender, marital status, degree of education and the presence of pain in the institutionalized aged people.

Tang and Pickard (2008) conducted a study of ageing in place or relocation. This study used data from the community partnership for older adults program. A survey conducted [N = 4,611] to examine associations between the perceived awareness of community-based long-term care and supportive services and the anticipation for ageing in place and relocation. Perceived availability and unavailability of services of community services was associated with the likelihood of anticipating ageing in place and relocation and awareness of the lack of visiting nurses, personal assistance or transportation was related to respondents reporting a younger age

at which they anticipated needing help to age in place or anticipating a need to relocate. Finding has implications for raising the public awareness of community-based services in addressing the needs of community-dwelling elders for ageing in place and relocation.

Tanner et al (2008) conducted a study about restoring and sustaining home and the impact of home modifications on the meaning of home for older people in Australia. This study examines the experience of older people living in the community who are recipients of a home modification service. It explores the impact modifying the physical environment has on their experience of home as a place of meaning and provides insight into how home modifications can strengthen the home as a place of personal and social meaning as well as improve safety and comfort for the older person at home. Care needs to be taken to ensure an awareness of the meaning of home to older people is embedded in the policy and practices surrounding the provision of home modifications.

Berg (2008) examined within – individual and between – individual changes in life satisfaction in the oldest –old using different time metrics and to study life satisfaction within the context of psychosocial and health-related variables. Four studies were conducted in this research, 702 individuals participated at the first occasion yielding an overall pairwise participant rate of 64%. At occasion 2, 3 and 4 the sample size was reduced to 568,430 and 315 respectively. The life satisfaction Index – Z was used. Analyses indicated that social network quality, self-rated overall health, the sense being in control of one's life, widowhood and depressive symptoms were associated with life satisfaction. Widowhood was significantly associated with lower satisfaction among men. Problems with sleep, urinary, incontinence and stroke were significantly related to life satisfaction in both men and women.

Louisa et al (2007) stated the assessment of Nutritional Status of older people in homes for the aged in the Somerset West area in South Africa. The descriptive, cross-sectional study design was used. A convenience sample of 4 homes for the aged, serviced by the same private catering company in the Somerset West area, were selected. Of the 380 older people living in these 4 old age homes, 210 complied with the above criteria and provided written consent to participate in the study. Food wastage was evaluated for 6 randomly selected meals at each old age home (2

breakfasts, 2 lunches and 2 suppers) by using the validated visual plate wastage method. The study population consisted of 53 males and 157 females with a mean age of 76.8 years, the mean height of 1.57 m and a mean weight of 63.3kg. The mean BMI was 25.6. They concluded that food acceptability was not related to nutritional status or plate wastage, although starchy foods, cooked vegetables and lunch protein dishes were wasted by half of the older people. There was a relationship between malnutrition and lower energy intake, emphasizing the need for meticulous menu planning and monitoring of food consumption.

Elina, Pekka and Anja (2007) published an article 'The condition and the risk of long term institutionalization among older people in Finland'. They used population-based follow-up data on older people aged 65 and above, to estimate the impact of different chronic conditions on the risk of long-term institutionalization. Furthermore, they analysed which chronic conditions were more strongly associated with the risk of institutionalization than with the risk of death without institutionalization. Cox proportional hazard regression models were used. Their results showed that dementia, Parkinson's disease, stroke, depressive symptoms, other mental health problems, hip fracture and diabetes were strongly associated with increased risk of long-term institutionalization, independent of socio-demographic cofounders and the presence of other chronic conditions. All these conditions raised the risk of institutionalization by 50% or more.

Dey (2007) conducted a study about the health status and health needs of old age home residents and establishment of minimum standards of health services in long stay institutions. Infrastructure assessment targeting on the management was conducted in 22 old age homes, identified by Help Age India. Health status and need assessment were conducted on 100 subjects (10 residents from ten old age homes). The quality of life score (WHOQOL-Bref) were significantly influenced by fee structure, working status, upper socio-economic class, exercise, separate room, activity schedule, picnics, sick rooms, doctors, trained nurses, yoga trainers, area per resident more than 120 sq. ft. in the home and higher staff to resident ratio.

Khan and Vandana (2007) analysed public-private old age homes in Delhi. The study was conducted in south Delhi covering 11 old age homes, out of which, only 7 were providing residential facilities. It was used for 36 residents. In free

homes, the inmates were satisfied with the facilities, provided by the homes. In paid homes their expectations from the authorities were high. Very few (2) respondents out of 14 were satisfied whereas the other 12 were not happy but they were living there out of compulsion. They want each individual should be treated as a separate identity. More than 1/3 inmates were brought by family members. About one-fourth of the inmates (22%) opt old age home because they did not want to be dependent. Hardly 8% of inmates made frequent interaction outside. Rest remained confined to home. Similarly, only 8% expressed willingness to return to their families, provided family members were keen and willing. Remaining 52% did not desire to go back. The finding also reveals that a little bit more than one-quarter of the inmates had no shelter and were truly in need of an OAH.

Mau-Roung Lin (2007) described the efficacy of three programs designed for reducing falls and improving quality of life among the elderly. Participants were assigned to one of the three fall prevention program groups, and quality of life was then assessed according to the world health organization's quality of life guidelines, focusing on four domains; physical capacity, psychological well-being, social relationships and environment. Although all programs appeared to lead to some improvement in inequality of life, improvements were significantly greater in the exercise training group. Exercise training participation also led to improvements in functional reach, balance and fear of falling. The quality of life benefits reflect not just health states, but also how patients perceive and value the health and non-health aspects of their conditions before and after receiving an intervention. These measures may, therefore, be beneficial for selecting interventions that are of optimal value to older people.

Omer Saka and Nebibe Varol (2007) analysed Institutional and community care for older people in Turkey. This study suggested that 25.2% of older people live in poverty without any regular income. This situation is particularly acute in the rural areas of the country, while the Government pays a quarterly salary to older people over 65; this is insufficient to meet needs. The majority of older people in Turkey do not have access to health and geriatric services. Malnourishment and depression are also significant problems. Living conditions and access to health care are in need of revision and improvement. Both the capacity and the quality of the

residential care institutions have to be improved. The number of qualified personnel both for social and health care has to be increased. Projects and programs to enable the social, cultural, economic and political involvement of older people should be supported.

Pappathi (2007) analysed the problems of ageing in India. She conducted case studies of the Old Age Homes in Dindigul District in Tamilnadu. She stated that 71% of the aged have the opinion that inmates of the old age homes are neglected by family members, 17% stated that they are interested to join old age homes and the remaining 12% reported that the old age homes cannot fulfil their basic needs. Majority of the inmates came from poor homes at their own wish. And they are willing to reside in the old age homes and do not want to return to their houses. Recreation facilities are available in all the old age homes. Majority of the inmates of the homes suffered from gastrointestinal, asthma, piles, diabetes, hypertension, arthritis, rheumatism, poor vision and hearing. All the aged have a cordial relationship with the management and freely interacted with other inmates.

Alexander et al (2006) in their article 'Factors associated with Oral Health-Related Quality of Life (OHRQOL) in institutionalized elderly in German' reported that some factors associated with OHRQOL. Authors selected 158 inmates. OHRQOL was measured using the Oral Health Impact Profile (OHIP). Denture characteristics and general issues were assessed. In the final linear regression model, general pain status, education level and retention of denture remained at a statistically significant level. The kind of denture had no significant impact on OHIP.

Madhu and Prema (2006) examined the Spiritual Intelligence of elderly people in Jaipur. For this purpose 200 senior citizens were selected from different living status i.e. living with family (N=100) and living in old age homes (N=100). The mean age of the aged persons was 69.4 years. Salahkaar Spiritual Quotient test (Sqi-t) was used for measuring spiritual intelligence. The test contains 15 dimensions and 99 items of spiritual intelligence. The mean score of overall spiritual intelligence of senior citizens living with family was 288.04 were as mean score of spiritual intelligence living in old age home was 289.28, which shows that the difference between the two groups was not significant. However, interpersonal relations, helping behaviour, flexibility, ability to use and overcome suffering domains of spiritual intelligence

revealed that senior citizens living in old age homes scored higher on these dimensions. The results obtained indicated that senior citizens were living in the family show a higher level of self-awareness and ability to transcend pains in comparison to senior citizens living in old age homes.

Prabhavathy and Tamilarasi (2006) in their study on Institutional care for the elderly in Chennai stated the problems of the inmates in old age homes. Background information of 400 senior citizens, both male and female in the age group of 60 to 80 years, was collected from 4 paid homes and 5 unpaid homes using an interview schedule. The pension was the most common source of income of male elderly in paid homes. The study also revealed that in paid homes 14% of the elders wanted to be independent without being a burden to their children. The most popular recreational activity among 31% of the elders seemed to be gathering day to day information on politics, sports and movies from dailies, while 27% were happy sharing their thoughts and feelings with their peer group. The elders were quite happy about food, shelter, clothing and safety. Only 22% were financially satisfied and 6% were psychologically satisfied.

Giovanni Colombo and Katya Smaniaa (2005) in their study 'Pet therapy and institutionalized elderly- A study on 144 cognitively unimpaired subjects' stated that the aim of the study was to assess whether a pet therapy program had a favourable effect psychopathological status and perception of the quality of life in cognitively unimpaired institutionalized elderly. Seven elderly rest homes in the Veneto Region of Northern Italy in the project, which was conducted on 144 cognitively intact elderly residents. The participants were randomly divided into three groups This study reinforces the hypothesis that pet therapy may have a beneficial effect on the psychological wellbeing of institutionalized elderly in particular aspects to depressive symptoms and perception of the quality of life.

Jasmeet Sandhu and Tripati Arora (2005) have attempted to highlight the condition of the institutionalized elderly in Punjab. The most commonly stated reason by the inmates for shifting to old age home was the conflict with their son-in-law and daughter-in-law. Only 17% of inmates stated that they came to the OAH to lead an independent and peaceful life without any interference. All the inmates expressed satisfaction with institutional care. All of them stated that they have good

friendly relations with the other inmates. They spent their leisure time by chatting, gossiping, watching Television and reading and by having discussions among themselves. Rather, they expressed their opinion that more old age homes are needed and society should make arrangements for the institutionalization of the elderly. As a result, of institutional living, they were able to construct their own community in which gender, class, caste and religious differences have no significance.

Marcelo, Eduardo and Clarissa (2005) examined the quality of life of the elderly in Brazil. 18 old people and 5 caregivers took part in the focus groups. All the focus groups followed a pre-established methodology. A tendency towards making an association between quality of life and wellbeing and feeling well was observed. The responses spontaneously included the six domains proposed in WHOQOL-100, thus corroborating the multidimensional nature of this construction. When questioned about the importance of each of the 24 facets of WHOQOL-100, the groups considered all of them to be relevant. However, suggestions for modifications to five facets were made. Additional items were also examined and considered relevant for assessing the quality of life among the elderly, by both the old people and the caregivers.

Mutran et al (2004) conducted a study about the elderly in old age homes in South Africa. The aim of this study was to describe physical activity knowledge, attitudes and practices of the elderly in Bloemfontein old age homes. From 11 old age homes 30% was chosen randomly, 390 residents participated in the study. Most participants were female (81.5%). Their age ranged from 65 to 101 years with a median of 78 years. The participants suffered mainly from Hypertension (48.5%), Arthritis (48.2%), Obesity (32.6%) and Osteoporosis (29.2%). Almost a quarter (23.1%) of the participants was not aware that exercise helps in controlling diabetes and cholesterol and 11.8% were unsure. Half of the participants (50.8%) were not satisfied with the facilities for physical exercise in their respective old age homes. The participants exercised an average of 5.75 times a week and for a median of 20 minutes. The participants had a positive attitude towards physical activity but lacked sufficient knowledge of physical fitness to be able to understand the benefits of regular exercise. Elderly people who do not exercise because of a specific health problem may be motivated to exercise in a way that improves the quality of life.

Das (2004) conducted a study on old age homes in the case of the elderly in Gujarat. Samples of 25 old age homes were selected across the various regions of the state of Gujarat. A total sample of 233 elderly inmates (men-114, women-119) was interviewed. Two-thirds of the elderly reported that they wash their own clothes, 19% reported that they clean the utensils used by them, and 13% stated that the sweeping and cleaning of the institute including their room was done by them. Out of 233, 14% of the elderly have reported that they do not have a health problem. A high percentage of inmates, (86%) reported their satisfaction with the various services provided in the old age homes. The major reasons reported for expressing satisfaction are because of good services and good behaviour of the staff (58%), food being palatable and wholesome (32), accommodation being satisfactory (27), and they have the freedom to participate in religious activities. Finally, they revealed that 63% were very happy or happy while 32 % are somewhat happy. Just 4% expressed the view that they are not happy with this living arrangement while less than 1% reserved their opinion on this aspect.

Ramamurti (2004) in his article 'Institutionalization of Elderly and Quality of Life' described that institutionalization of the elderly is the last resort in the Indian culture. A variety of reasons are stated by those elderly who seek institutional care. But often the institutions are not replacing a homely atmosphere. In many institutions, the quality of life of the elderly leaves much to be desired. The management of these institutions is also not very satisfactory. These institutions offer an alternative to family care is a moot point. A survey of institutions for the elderly in different regions of Andhra Pradesh funded by the Department of Welfare, Government of India, provides useful observations.

Andreas Motel-Klingebiel (2004) in her study 'Quality of Life and Social inequality in old age' stated age dependency of inequality structures. The theoretical concepts guided the empirical analyses of the quality of life and social inequality in later life. The analyses demonstrated that lower levels of quality of life in old age found in all the participating countries (Norway, England, Germany, Spain, and Israel). At the same time, there was a significantly higher degree of variation in older age groups than in the younger population. Social relations lose importance for the

perceived quality of life among older people, while health-related dimensions especially physical health were the most relevant in later life.

Sreevals and Nair (2004) reviewed the elderly in old age homes in Kerala. From 8 randomly selected OAHs, 157 inmates were selected. Results revealed that the majority of the inmates (58%) were females. Out of 157 inmates, 66% joined the OAHs voluntarily and 30% were brought in by their children. The proportion of inmates who arrived due to family problems was higher than that of those who arrived due to economic reasons. Only 63% of the inmates were found to be satisfied with their life in the OAHs. The quality of food served in the OAHs was found to be a consistently good and a significant predictor of the satisfaction of the inmates. A significant relationship was observed between the type of OAHs and the satisfaction of the inmates. The quality of food was the most significant predictor of satisfaction of the elderly. There was no significant relationship found between satisfaction and day-to-day activities of the inmates. The health expenditure and quality of food were found to be highly significant factors for the satisfaction of the aged people. It was found that the reasons for moving to OAHs and the willingness to go back had a significant relationship.

Breeze (2004) examined the association of quality of life in old age in Britain with the socio-economic position. Response to the quality of life interview varied little by gender and age. Altogether 6298 (73.5%) of 8565 completed a brief assessment. The response was lowest (63%) among women aged 85 years and over. The median age was 80 years and nearly 40% of the participants were males. Over half were in the independent owner-occupied category and 20% were in the independent rented one. Percentage independent groups were small and one in six participants lived in supported housing. Quality of life scores were generally low (that is, good), especially for self-care basic difficulties. Median scores were higher for women than men (not significantly so for social interaction) and increased with age but only marginally for morale.

Borowiak and Kostka (2004) described the correlations of QOL in home-dwelling and institutionalized elderly. 152 elderly residents of long-term care homes and 160 community-dwelling elderly participated in the study. The assessment included demographic and social variables, health status, and nutritional status, physical and

cognitive function. Depression was the most powerful predictor of QOL in both community-dwelling and institutionalized elderly. Complaints associated with the musculoskeletal system in community-dwelling elders and manifestations of atherosclerosis and cardiovascular diseases in institutionalized elders were the most important concomitant diseases. Regular participation in PA, preventing obesity and maintaining an adequate level of physical and cognitive function, contributed more to overall QOL in community-dwellers than in older and frailer institutionalized elderly adults. Physical and cognitive function deficits, overweight/obesity, and lack of regular PA are among primary predictors of decreased QOL in home-dwelling elders. In institutionalized subjects, these functional/behavioural data seem to be of lesser importance, the role of concomitant diseases becoming dominant.

Kamlesh, Ajit and Rajesh (2003) published an article 'Health-related quality of life (HRQOL) among the elderly in northern India'. A cross-sectional survey chosen by a cluster sampling technique consisting of 200 elderly subjects (100 each from rural and urban areas) was carried out in Chandigarh city. Almost 62% of the elderly had HRQOL score above a median of 69. Psychological well-being (0.85), disability (0.82) and social support (0.71) were found to have an almost identical influence on HRQOL score. In univariate analysis, a better HRQOL was seen among those in the lower age group, literates, urban residents and those with high personal income and living in large households. In multivariate analysis, HRQOL was found significantly associated with age, sex and occupational status. The reproducibility and validation of the measure were found to be satisfactory.

Jasmeet Sandhu (2003) points out the reasons for the inmates who took shelter in the old age home at Khalsa Peharak Vidyalaya. She states that they had no sons and did not want to live with their married daughters (8 per cent). Conflicting relations with sons or in-laws (44 per cent) were also the other reasons expressed by them. Independent and peaceful life (18 per cent), feeling of loneliness (16 per cent), and empty nest feeling (14 per cent) also forced them to the old age homes.

Agarwal (2003) ascertained the opinion of inmates (widows) and found that the majority (80%) of them had taken shelter because of lack of adjustment with members of the family and due to a feeling of unwanted at home and economic dependence. Very few (10%) stated that their children are outside India but supported

them financially. The remaining 10% do not have children or close relatives to live with and so they took shelter in the old age home. In a home called Swami Satyanand Sevadham Viradheshram, all the inmates are satisfied with the socio-economic conditions, medical care and recreational avenues. They have meditation, kirtan (group religious songs), and self-study and listened to the inspiring talk of the founder 'saint'. These activities and counselling often help them in developing a feeling of self-satisfaction and self-esteem.

Mizue et al (2002) examined the relationship between fear of falling, activities of daily living and quality of life among elderly individuals. Health-related quality of life concepts was measured using the Short Form 36 Health Survey (SF-36) within an elderly day services sample. The study identified 43 males and 92 females as eligible for the study. Of the studied, 49 elders (36.3%) expressed no fear of falling, whereas 22 (16.3%) reported that they were very fearful of falling. Among females, walking and bathing had a highly significant relationship with the fear of falling. The fear of falling can contribute to psychological conditions such as depression, and also impacts on the health-related quality of life of frail elderly people. Thus, the study concluded that it was critical to provide integrated health care activities for elders that address both psychological well-being and physical functioning.

Gurusamy (2002) explained the existing socio-psychological atmosphere within the family such as alienation, the domination of daughter-in-law, loss of social status, neglect, improper accommodation, limited social participation and ill-treatment by family members forced the rural aged to take refuge in old age homes. The aged who are receiving survival assistance of 15 kg of rice, 1 kg pulses and Rs.100 per month from an NGO are treated better by their family members when compared to their other counterparts. Counselling plays a positive role among the elderly, especially widows, which provides better adjustment, minimize the generation gap and reduce tensions in life, develop a healthy mental attitude towards life and ensure happy ageing. The services of voluntary social welfare organizations help to bring about a spirit of joy, hope and happiness in their life.

Jkh Luk (2002) stated the private services to old age homes in Hong Kong were clusters. The study covered 316 residents of age 60 or above being seen by community geriatric assessment teams (CGATs) for 6 months. The Private homes

largely outnumber the sub rented ones and the quality of care is in the general inferior and the careers are usually untrained and with insufficient nursing and medical knowledge. Most of the residents are frail with multiple geriatric problems. The present study demonstrated that CGAT to private old age home could reduce more than half of the outpatient clinic attendance; hence the POAH staff could have more time and energy to improve the quality of care to the residents. It was also encouraging to see that many specialists in the outpatient speciality clinics recognized the above benefits of CGAT and had referred their patients to CGAT for long term management.

Haken et al (2002) in their study presented an alternative assessment method for establishing the demand for an old age home among a community-dwelling older population. The result shows that the subjective demand as measured by the 'Orientation toward admission into an old age home' is indeed related to the actual use of an old age home. The subjective demand as measured by being and a waiting list are not significantly related to the use of an old age home. The level of physical impairments and age are sometimes, but not always significantly related to the use of an old age home. They concluded that the instrument 'Orientation' with a valuable instrument in assessing 'Subjective demand' for an old age home among community-dwelling older people.

Chopra and Anand (2001) found that people living in families as compared to old age homes when measured on psychological and social aspects were better. Family residents were fully engaged in Social activities and well connected with Kit and Kin.

Jayaseelan (2001) examined the reasons for the inmates taking shelter in old age homes in Madurai and their status in the old age homes. The study pointed out that many of the institutionalized elderly were treated badly by their daughter-in-law. There was no cordial relationship between daughter-in-law and mother-in-law. Negligence and careless treatment by the members of the family were reported and most of the inmates were not willing to stay with their family even during sickness. They are satisfied with the facilities, treatment and security provided by the institution.

Canga Armayor (2001) in his study 'The institutionalized elderly- How do they perceive old age?' stated that quality of life is a criterion set which is evaluated by

each human being. In order to evaluate it, one's personal opinion and satisfaction are indispensable. What does the quality of life mean for an elderly person who is institutionalized? The author carried out this study in order to answer the question by means of a descriptive and transversal method, one objective was to evaluate the perception of the quality of life for institutionalized elderly held by each of the aforementioned groups. The study group for this research project was composed of elderly people living as permanent residents in an institution and the business administrators' managers and caretaking personnel in three geriatric centres in Navarra.

Salari and Rich (2001) examined the social environments, staff behaviour and social interaction of elderly clients in 2 adult day-care centres. Using qualitative research techniques, the environments, activities and interactions of approximately 72 clients in 2 adult day care settings were examined. Data indicate that the clients have lower social interaction with peers when the staff and environment are more infantilizing, provide less autonomy and have fewer opportunities for privacy regulation. In contrast, when the centre has a more adult setting, with age-appropriate activities, there is greater privacy regulation, autonomy, social contact and friendships among clients.

Mutran et al (2001) compared African-American and white elderly residents' sources of satisfaction with care provided in adult care homes. In all, 143 African-American and 214 white elderly individuals (aged 65 years) living in adult care homes in North Carolina completed questionnaires concerning satisfaction with care, satisfaction with staff, overall satisfaction, intrapersonal characteristics and interpersonal relationships. Results show that African-American samples were less satisfied with their care and their homes. African-American samples were more satisfied in smaller homes, were not affected by family contact and appeared to be more affected by organizational factors such as a number of private rooms and turnover rate at the facility. For white samples, the level of dependency directly influenced ratings of overall satisfaction. For African-American samples, dependency indirectly influenced ratings of overall satisfaction through the more specific measures of feeling at home in the facility and satisfaction with staff.

Sobha, Vijayalakshmi and Reddy (2001) conducted a study in Chittor district, Andhra Pradesh. The respondents were 60 women residents of the homes for

the aged, selected on a random basis. The study found that 100% companionship was required by the aged. 83.3% food security, 66.7% emotional security, 50% health security, and 16.7% economic securities were required by the aged. A majority (83.3%) of the institutions had first aid facilities. Further respondents said that referral services (41.7 %), subsidized health care (33.3%) and timely health care (25%) were lacking. In this study, the expectations of the aged from the institutions have been collected. All respondents had expressed varying levels of dissatisfaction with the supportive services and care provided by the institutions where they reside.

Mangayarkarasu (2001) in his article 'Old Age programmes and policies in India', stated that old-age programmes provide physical, social, emotional, psychological and economic aids to the aged. The old age home would be the residential unit for at least 25 poor/destitute aged persons of the 60 years and above. If old age homes are the way out, many of them would turn out to be dumping homes. Love, loyalty and affection would become causality. Middle-class values would get totally eroded. Financial institutions like banks, religious and charitable bodies may also come forward to fulfil this obligation to society.

Gaur and Kaur (2001) studied the institutionalized and non-institutionalized elderly. It was reported that non-institutionalized elderly had a higher score for life satisfaction than institutionalized elderly. The males as a whole had higher life satisfaction score than females. Also, the non-institutionalized elderly are much better adjusted and more satisfied than institutionalized elderly. Institutionalized elderly are isolated from the community in a set up that does not give autonomy and independence.

Jacob John Kattakayam (2000) conducted a comparative study of Elderly care by families and Institutions in Kerala. For the study, 100 respondents were selected from families and 100 respondents from Old Age Homes. It was found that 68% of the elders who stayed in the homes did not have their spouse alive whereas 78% of the elders staying in the houses had their spouse alive. It was observed that 67% of the aged in the homes did not have an independent income whereas 68% of the aged residing in the households had an independent income. A high percentage (89.83%) of inmates and 37.93% of elders living in households reported that they felt insecure. The study also reported that as many as 75% of the respondents were in need of medical care.

Comparatively, access to health care for the elders in old age homes was better than those living in the households. The regular health check-up in the old age homes gave physical and psychological well-being for the elders, it was reported. Though both the groups have deprivations, the aged who stay in the old age homes more deprived than those who stay in the households.

Pushpa Mary Rani, (2000) in her article 'Institutional Care of the Aged' stated that the care of the aged traditionally had been the concern and responsibility of the family. On account of several reasons, taking care of the aged has become a serious problem. Therefore, numerous institutions which take care of the old, and are managed both by government and voluntary organizations, have come into being. These institutions provide a wide range of services such as residential care, day-care, geriatric care, medical care, recreation and counselling. The article is based on an empirical study of an institution named 'Home for the Aged' situated in Hyderabad, Andhra Pradesh. The results reveal that ageing is not just biological but psychological and sociological too.

Gillis Samuelsson and Michel Allard (2000) in their article on 'Centenarians in France, Georgia, Hungary and Sweden Social Characteristics' reported that in the Swedish Population 75% elderly people live in old age homes, in France 55%, in Hungary 10% and none in the Georgian Population. Females more often lived in institutions than males except for Hungary where males were in the majority. Regarding the high institutional rate in Sweden, compared with eleven other European countries, the percentage of elderly (69+) living in institutions was in Sweden the same as in France (6%) and in several other European countries.

Reena (2000) stated that the major reasons for seeking shelter at old age homes are low economic status, widowhood, destitution, abuse by family members and lack of support from social networks. The institutionalized aged faces more problems than the non-institutionalized aged. In the institutions, no one advises the aged to take care of their health and for getting medical treatment. The chronic diseases like asthma, diabetes, ulcer, hypertension, arthritis and breathing problem need not only regular medical check-up but also strict dietary regulations which can be provided only in their home by their family members.

Chou, Kee-Lee and Chi, Iris (2000) in their study 'Comparison between Elderly Chinese living alone and those living with others' explained that elderly persons living alone were younger and were less likely to be married. Compared to the elderly respondents living with others the younger ones had poor health status and a higher level of financial strain. They also reported a smaller social network of relatives, less instrumental and emotional support and reported more depressive symptoms and a lower level of quality of life.

Packiam (2000) pointed out the conditions of old age homes. Some old age homes run by trusts and welfare clubs which solely depends upon donations and mere subscription from members. So the living conditions in such homes are far from satisfactory. He mentioned some suggestions to improve the functioning of old age homes. They are 1. Economic supports are to be mobilized from Government, non-government agencies and the general public. 2. Care to be taken to establish old age homes in the city or close to the city. When the homes are situated far away the old are totally isolated. 3. Efforts are to be taken up to install in the minds of the young respect and concern for the old and motivate them to visit old age homes.

Borowiak Ewa and Kostka Tomasz (2000) described the predictors of quality of life in older people living at home and in institutions. The aim of the study was to describe the correlation of quality of life in home-dwelling and institutionalized elderly. In the study, 152 elderly residents of long-term care homes and 160 community-dwelling elderly participated. The relative contribution of functional and medical co-morbidities, as well as health-promoting behaviour to QOL, may be different in community-dwelling and institutionalized elders. Physical and cognitive function deficits, overweight and lack of regular physical activity were among primary predictors of decreases in quality of life in home-dwelling elders. In institutionalized subjects, these functional, data seem to be were positively correlated with both lesser importance, the role of concomitant diseases becoming dominant.

Perold and Mulloer (2000) analysed the old age homes in South Africa in relation to the residents and nursing personnel. The study aimed to describe the composition of the residents and nursing personnel of old age homes. The residents were mainly female (77%), older than 85 years of age. It was mentioned by nurses who participated in Interview experienced that a lot of time spent on resolving conflicts

which resulted from poor communication between residents and caregivers as well as supervisors and caregivers. It appears that the overall serious shortage of registered nurses in OAH is critical at some OAHs. Five old age homes indicated that they had no professional registered nurse. Sixteen OAHs had only one registered nurse and 30 had two registered nurses. This study recommended that communication skills and cultural sensitivity should be included in the training courses of nursing personnel in old age homes.

Shyam and Yadav (2000) in their study, a sample of 60 elderly (30 institutionalized and 30 non-institutionalized) were administered well-being measure, health questionnaire and social support questionnaire. The non-institutionalized subjects reported significantly high depression also life satisfaction was high in institutionalized subjects.

2.3 Summary

The literature review has analysed different conditions of elderly people in old age homes both in India and in the world at larger. It has raised a number of aspects related to the elderly in old age homes. The first issue is to do with how poverty and old age are closely linked. The literature has presented a number of aspects which contribute to the elderly being more vulnerable to poverty and these include the absence of a reliable income and the inability of elderly people to fulfil economic responsibilities among other reasons.

In summary, the literature studied on the elderly and old age homes in India reveals two important issues. Firstly, paid old age homes were more privileged than the free old age homes. This was due to the fact that paid institutions were better financed by their inmates and the free institutions were supported by their donors only. Secondly, it revealed that institutions for the elderly seemed to go a long way in improving the quality of life of those elderly people who were admitted to them, and did not have anyone to care for them.

The majority of literature was obtained from different internationally recognised journals such as Journal of Advanced Nursing, Journal of Gerontological Nursing, The Gerontologist, International Journal of Nursing Studies, Scandinavian

Journal of Caring Sciences, Nursing Ethics, Quality of Life Research, and Journal of Gerontology. Research papers from the above journals were selected according to international recognition of the journal, citations and topics similar to the study, thus allowing direct comparison of obtained results.

The review of literature also traced how their role and position in society has changed over time. After looking at the different problems facing by the elderly in the old age home has presented by different authors, the literature review also presented the loopholes that have been identified in existing social security policies in the developing world. However, many studies have been undertaken to document the condition of the elderly in the country and those living in old age homes. The present research study corroborates with other studies reviewed regarding this particular viewpoint in Indian context specifically in Tamilnadu.

Research on the condition of institutionalized elderly describes it as a social problem. Many studies that were reviewed have focused on themes of socio-economic background, life satisfaction, living environment, socio-economic support and health status of elderly in old age homes. But the present study varies from other studies in that it takes up all the vital aspects by studying the various themes of life satisfaction of elderly people in old age homes, Tamilnadu state of India.

CHAPTER III

Research methodology

3.1 Statement of the problem

The status of the elderly has changed in the present family system. Earlier, aged members were regarded as having supreme power and their experience and wisdom were utilized to solve important family issues. The feeling of loneliness along with the natural age-related decline in physical and psychological functioning makes them prone to psychological disturbances. In some cases, elderly members of relatively rich families or aged persons who have nobody to look after takes shelter in old age homes. The elderly live in these homes just to complete the last phase of their lives (Ghosh, 2006).

Old age homes have begun to expand rapidly in most of the metropolitan areas in India. The concept of old age homes is not new in India as there were such facilities to care for destitute older adults as far back as the 18^{th} century (Nair, 1995). What is new in India is the concept of 'pay and stay' homes that cater primarily to middle class older adults, which is affordable only for middle or higher-income families. They are being sought by many older adults as a viable alternative to a life of feeling marginalized and discriminated.

3.2 Research design

In this study, a descriptive research design was adopted. It described and analysed the life satisfaction, living environment, socio-economic support and health status of elderly people in old age homes. It aimed at gaining new insights into the needs and problems of the institutionalized elderly.

The study also aimed at portraying, as faithfully as possible, the characteristics of the aged people. At various points, the study planned to determine the association of one variable with the other. Efforts have also been made to minimize the bias and maximize the reliability of the data collected.

3.3 Objectives of the study

The main objectives of the study are;

1) To understand the socio-economic background of the elderly people living in old age homes in Tamilnadu,
2) To find out the life satisfaction of inmates in old age homes,
3) To identify the living environment of inmates in old age homes,
4) To assess the social support and economic support received by the inmates and
5) To analyse the health status of inmates and the requirement of medical aids and substances in old age homes.

3.4 Area of the study

The study was conducted in Tamilnadu, India. According to the 2011 census, there were 32 districts in Tamilnadu. First, four highly populated districts (census, 2011) of Tamilnadu were selected for research work. They are 1) Chennai, 2) Kanchipuram, 3) Vellore and 4) Thiruvallur.

Figure 3.1 Tamilnadu map in India

Figure 3.2 Study areas in Tamilnadu

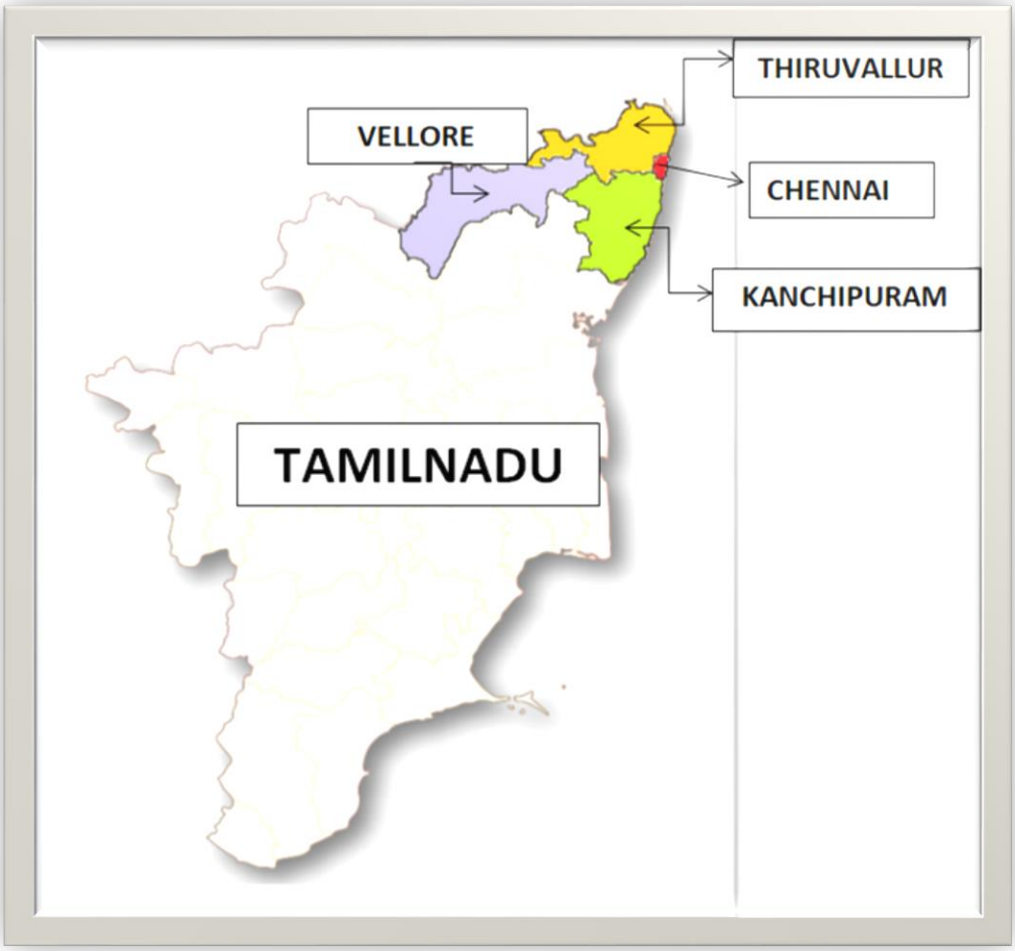


Table 3.1 First four highly populated districts in Tamilnadu

Districts	Population (2011)	Sex Ratio (2011)	Child Sex Ratio (2011)
TAMIL NADU	68515977	987	942
Chennai	4681087	986	964
Kancheepuram	3990897	985	967
Vellore	3928106	1004	944
Thiruvallur	3725697	983	954

According to the 2011 census, 68,515,977 people were living in Tamilnadu. Highest population were living in Chennai (4,681,087) followed by Kanchipuram (3,990,897), Vellore (3,928,106) and Thiruvallur (3,725,697). The field study was conducted in old age homes in Chennai, Kanchipuram, Vellore and Thiruvallur in 2018. From each district, five old age homes were studied. Totally the research was conducted in 20 old age homes in Tamilnadu.

3.4.1 Study area 1: Chennai district

The research was conducted in Chennai city among various old age homes. Chennai is the capital of Tamil Nadu. Located on the Coromandel Coast of the Bay of Bengal, it is a primarily cultural, economic and educational centre of south India. In 2011, the jurisdiction of the Chennai Corporation was expanded from 174 km^2 (67 sq. mi) to an area of 426 km^2 (164 sq. mi), dividing into three regions; North, South and Central, which covers 200 wards.

According to 2011 census, the city had a population of 4,681,087, with a density of 26,903 per km² administered by the Municipal Corporation; that had 11 lakh households, with 51% of them living in rented houses. The city's limits were expanded later in 2011 and its population reached 7,088,000 with Chennai Municipal Corporation being renamed as Greater Chennai Corporation. The city registered a growth rate of 7.8% during the period 2001–2011.

The Chennai metropolitan area is the fourth most populated agglomeration in India and 31st largest urban area in the world. The sex ratio is 951 females for every 1,000 males, slightly higher than the national average of 944. The average literacy rate rose from 85.33% in 2001 to 90.33% in 2011 much higher than the national average of 79.5%. However, the city has the fourth highest population of slum dwellers among major cities in India, with about 820,000 people (18.6% of the city's population) living in slum conditions.

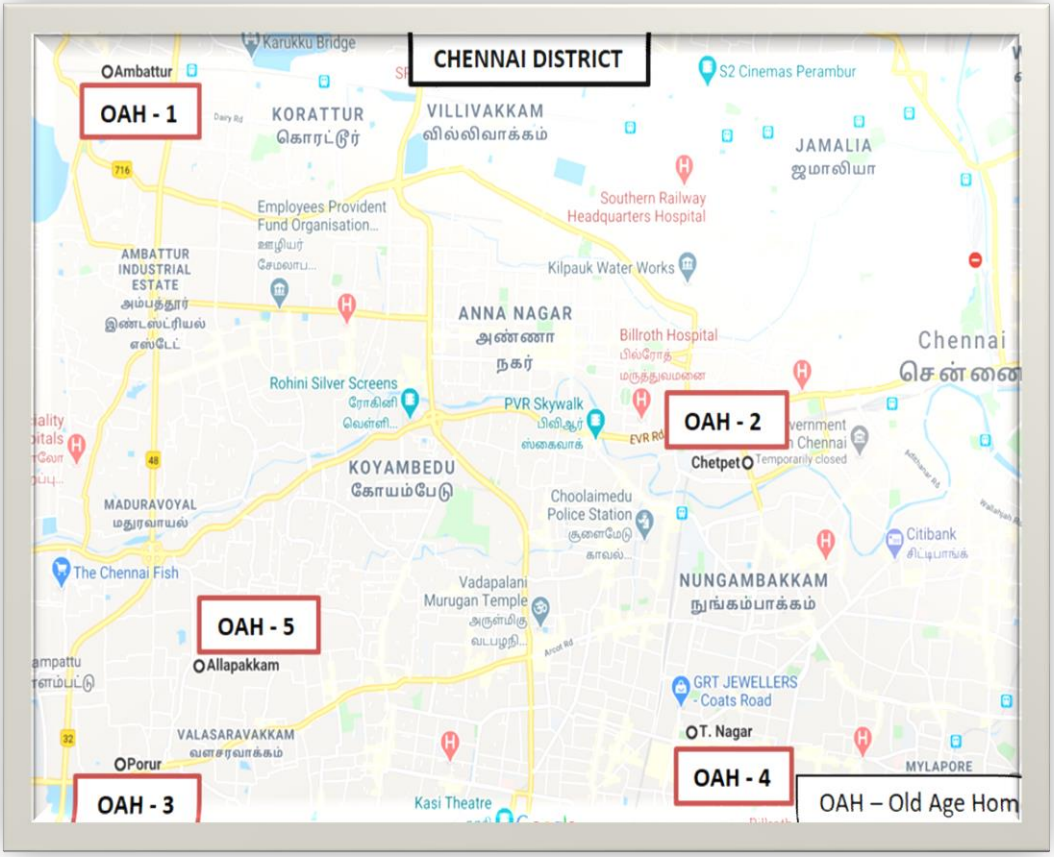
As of 2019, 712,000 families live below poverty line, which is about 40 per cent of the 1.788 million families in the city.

Figure 3.3 location map of Chennai in Tamilnadu

Table 3.2 list of old age homes in Chennai district

Old age homes	Category	Type
OAH - 1	For men & women	Free home
OAH - 2	For men & women	Free home
OAH - 3	For men & women	Paid home
OAH - 4	Only for women	Free / Paid home
OAH - 5	For men & women	Paid home

Figure 3.4 location map of old age homes in Chennai district



3.4.2 Study area 2: Kanchipuram district

According to 2011 census, Kancheepuram district had a population of 3,998,252 with a sex-ratio of 986 females for every 1,000 males, much above the national average of 929. The population of male and female was 1,961,688 and 1,974,643 respectively.

The average literacy of the district was 75.37%, compared to the national average of 72.99%. The district had a total of 1,006,245 households. There were a total of 1,673,814 workers, comprising 74,761 cultivators, 162,494 main agricultural labourers, 41,149 in household industries, 1,088,974 other workers, 306,436 marginal workers, 14,582 marginal cultivators, 110,020 marginal agricultural labourers, 13,583 marginal workers in household industries and 168,251 other marginal workers.

Kancheepuram district is situated on the northern East Coast of Tamil Nadu and is adjacent by Bay of Bengal and Chennai city and is bounded in the west by

Vellore and Thiruvannamalai district, in the north by Thiruvallur district and Chennai district, in the south by Villupuram district in the east by the Bay of Bengal. The district has a total geographical area of 4393.37 Sq. Km and coastline of 87.2 Km. Kancheepuram, the temple town is the district headquarters. For administrative reasons, the district has been divided into 4 revenue divisions comprising of 13 taluks with 1137 revenue villages. For development reasons, it is divided into 13 development blocks with 633 Village Panchayats.

Figure 3.5 Location map of Kanchipuram district in Tamilnadu

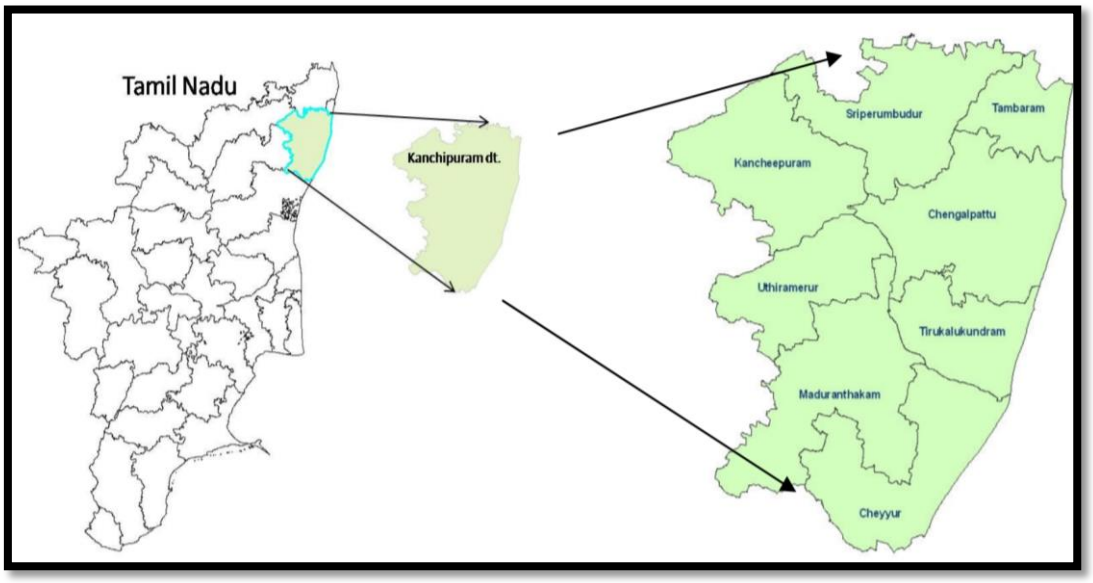
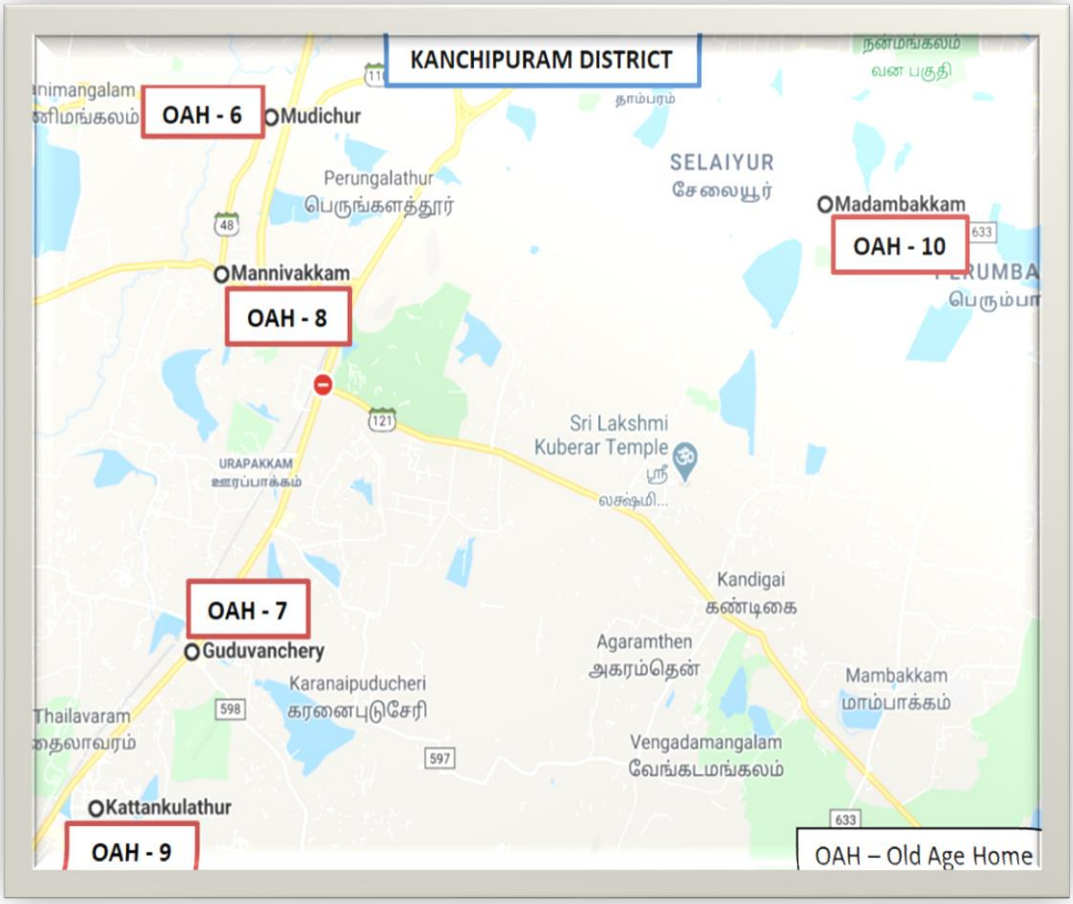


Table 3.3 list of old age homes in Kanchipuram district

Old age homes	Category	Type
OAH – 6	For men & women	Free home
OAH – 7	For men & women	Free / Paid home
OAH – 8	For men & women	Paid home
OAH – 9	For men & women	Paid home
OAH - 10	For men & women	Paid home

In Kanchipuram district, the majority of old age homes were paid homes. Some homes provide all facilities and collect money from the inmates. But some free homes do great service to the poor inmates.

Figure 3.6 location map of old age homes in Kanchipuram district



3.4.3 Study area 3: Vellore district

According to 2011 census, Vellore district had a population of 3,936,331 with a sex ratio of 1,007 females for every 1,000 males, much above the national average of 929. Male and female population was 1,961,688 and 1,974,643 respectively. The density of Vellore district for 2011 is 648 people per sq. km. Vellore district administer 6,075 square kilometers of areas. Average literacy rate of Vellore in 2011 were 79.17 compared to 72.36 of 2001. The district is bound on the northeast by Thiruvallur District, on the southeast by Kanchipuram District, on the south by Tiruvannamalai District, on the southwest by Krishnagiri District, and on the northwest and north by Andhra Pradesh state. On 15 August 2019, the district was trifurcated into Vellore, Tirupattur and Ranipet districts.

Vellore is the main city and the administrative headquarters of Vellore district. It is one of 27 cities chosen by the Government of India to take part in the

country's Smart Cities Mission. Vellore is known as the leather hub of India. Hundreds of leather and tannery facilities are around Vellore and nearby towns, such as Ranipet, Ambur and Vaniyambadi.

Figure 3.7 Location map of Vellore district in Tamilnadu

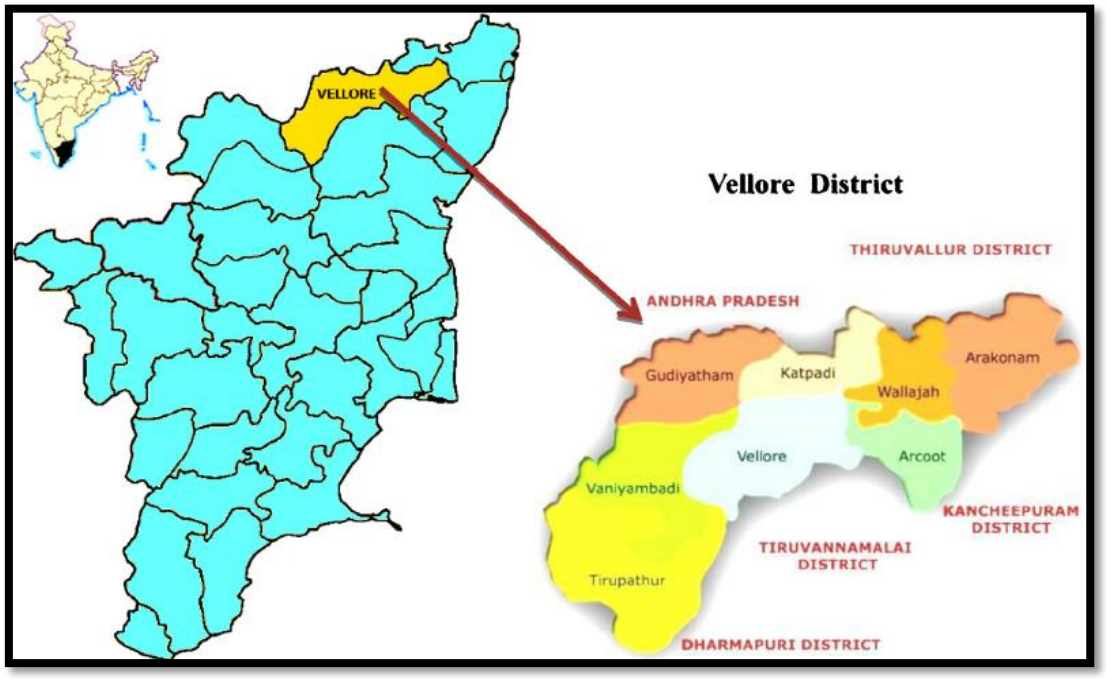


Table 3.4 list of old age homes in Vellore district

Old age homes	Category	Type
OAH – 11	For men & women	Free home
OAH – 12	For men & women	Free home
OAH – 13	Only for women	Free home
OAH – 14	For men & women	Free home
OAH - 15	For men & women	Paid home

In Vellore district, the majority of old age homes are run by a charitable trust. Very few homes are paid homes. Christian missionaries maintain free old age homes with good facilities in Vellore district. One of the old age homes is attached with an orphanage and they all live together like a family. They maintain the relation of grant parent and grant children in that home. Some homes provide vegetarian and non-vegetarian food to the inmates based on their wish. Majority of old age homes (free homes and paid homes) conduct a routine medical check-up to their inmates.

Figure 3.8 location map of old age homes in Vellore district

3.4.4 Study area 4: Thiruvallur district

Thiruvallur District is an administrative district in the Indian state of Tamil Nadu. The district has a mixture of urban and rural characteristics. It has been divided into three revenue divisions of Thiruvallur, Tiruttani and Ponneri. Likewise, there are 12 blocks, 5 Municipalities and 10 town panchayats which implement rural development activities.

According to 2011 census, Thiruvallur district had a population of 3,728,104 of which male and female were 1,876,062 and 1,852,042 respectively, with a sex-ratio of 987 females for every 1,000 males, much above the national average of 929. A total of 405,669 were under the age of six, constituting 208,449 males and 197,220 females. The average literacy of the district was 74.88%, compared to the national average of 72.99%.

The district had a total of 946,949 households. There were a total of 1,538,054 workers, comprising 60,436 cultivators, 173,150 main agricultural labourers, 41,742 in household industries, 972,590 other workers, 290,136 marginal workers, 13,008 marginal cultivators, 97,436 marginal agricultural labourers, 16,498 marginal

workers in household industries and 163,194 other marginal workers. Thiruvallur district administers 3,394 square kilometers of areas. Thiruvallur district is one of the fastest developing districts in Tamil Nadu in terms of Industrial Development.

Figure 3.9 Location map of Thiruvallur district in Tamilnadu

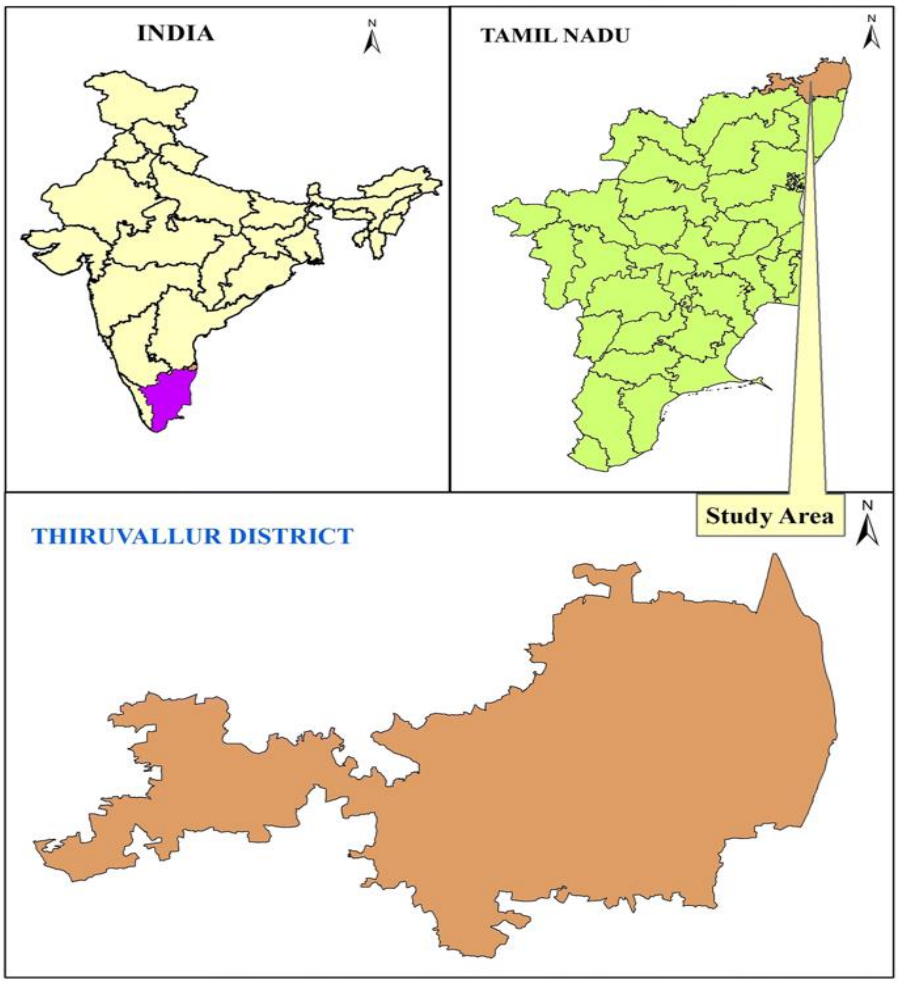
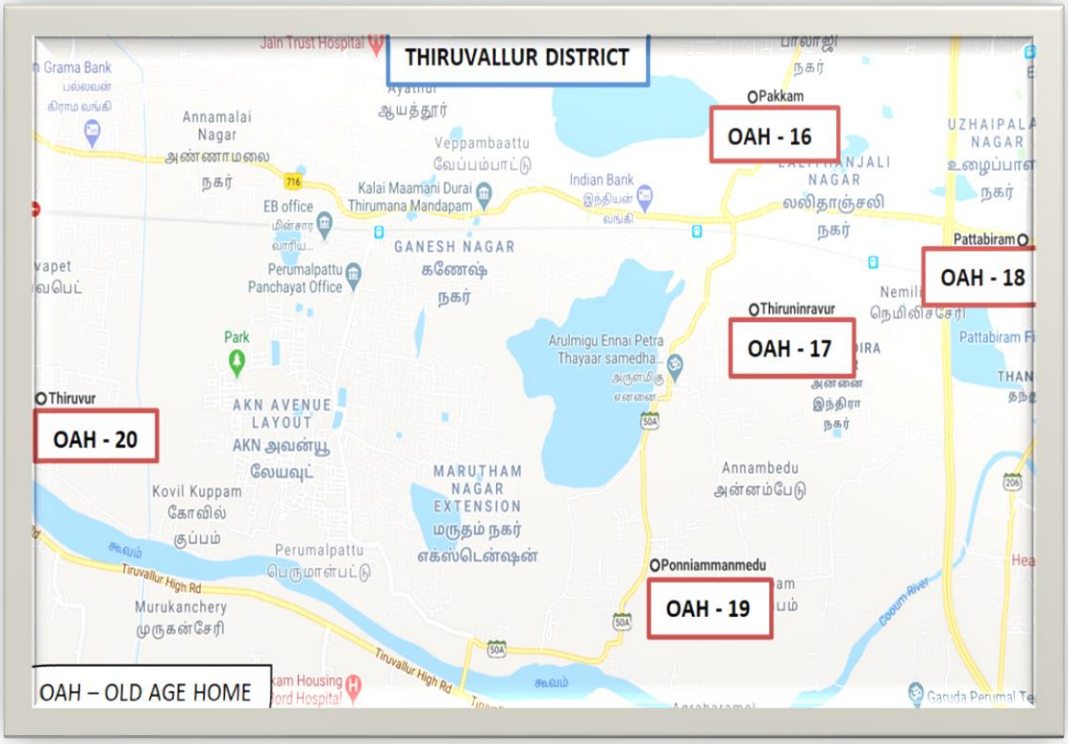


Table 3.5 list of old age homes in Thiruvallur district

Old age homes	Category	Type
OAH – 16	For men & women	Free home
OAH – 17	For men & women	Free / Paid home
OAH – 18	Only for women	Free home
OAH – 19	For men & women	Paid home
OAH - 20	For men & women	Paid home

Figure 3.10 location map of old age homes in Thiruvallur district



The old age homes are categorized into three types. They are free homes, paid homes and free-cum-paid homes. Among these three types, some homes are run exclusively for women, some for men and some for men and women.

Table 3.6 Types of old age homes

District	Free homes	Paid homes	Free-cum-paid homes	Total
Chennai	2	2	1	5
Kanchipuram	1	3	1	5
Vellore	4	1	0	5
Thiruvallur	2	2	1	5
Total	**9**	**8**	**3**	**20**

The above table (3.6) describes the types of selected old age homes. In this research, 20 old age homes were interviewed. Out of 20 homes, 9 were free homes, 8 were paid homes and 3 were free-cum-paid homes.

3.5 Sample selection

In the above mentioned 20 homes, there were 936 inmates. Purposive sampling method was used to select the inmates for the present study. Inclusion and exclusion criteria were used for the selection of samples.

Table 3.7 Criteria for the selection of inmates

Exclusion criteria	Inclusion criteria
Below aged 60 years	Aged 60 and above
Bedridden	Ability to do their work
Mentally retarded	Male and Female

Persons aged less than 60 years, mentally retarded and bedridden were excluded from the sample selection **(**Table 3.7). Thus, the selected 710 persons were 60 years and above and were residing in old age homes in Chennai, Kanchipuram, Vellore and Thiruvallur districts. The selected 710 sample inmates include 182 men and 528 women (Table 3.8).

Table 3.8 List of selected inmates in old age homes

District	Number of inmates		
	Men	**Women**	**Total**
Chennai	54	208	262
Kanchipuram	52	108	160
Vellore	16	118	134
Thiruvallur	60	94	154
Number of inmates	**182**	**528**	**710**

3.6 Method of data collection

Both primary and secondary data were used in this study. Primary data were collected by using a structured interview schedule from elderly people living in old age homes. The interview schedule was prepared in English and later it was translated into Tamil. They were asked and interviewed in the regional language, Tamil which was the mother tongue of most of the respondents. A brief introduction about the researcher was

given to the respondents. Then a detailed explanation regarding the purpose of the study and cooperation expected from the respondents during the data collection were also explained. The consent was obtained from the old age homes and the confidentiality of the responses was assured.

A structured interview schedule was used to collect data from the selected sample cases. A good amount of time was spent with each inmate for collecting the required information. The interview schedule was divided into five sections. They are followed;

a) Socio-economic background of the elderly people in old age homes
b) Life satisfaction of inmates
c) The living environment of inmates in old age homes
d) Socio-economic support to inmates
e) Health status of inmates.

The first section of interview schedule comprised of socio-economic information covering a diverse set of parameters as age, sex, marital status, education, number of children, type of family, employment status, duration of stay, the reason to join in old age home and etc.

The second section of the interview schedule consists of information about the life satisfaction of inmates. Satisfactions with Life Scale (SWLS) and Oxford Happiness Questionnaire (OHQ) have been used in this section.

The third section explains the living environments of inmates in their old age home such as nature of accommodation, entertainment facilities, room feature, special feature and etc.

The fourth section consists of questions about social support and economic support to the inmates by their family members and friends. Questions about the social security schemes of elderly people have been included.

The fifth section of the interview schedule collects information about the health status of inmates, their diseases and the availability of medical facilities. Short Form 36 (SF-36) has been used to evaluate the health status of inmates.

Research Tool 1:

According to the research conducted on the validity of life satisfaction scales, one of the main measurements is based on preferences and values of people (Diener, Inglehart & Tay, 2013). Satisfaction with Life Scale (SWLS) is a short 5-item instrument designed to measure global cognitive judgments with life. It takes just 1 minute to complete. Below are five statements that may agree or disagree with. Using the 1 - 7 scale below, indicate agreement with each item by placing the appropriate number on the line preceding that item.

Table 3.9 Satisfaction with life scale

Sl. no	**Statements**	**S.A**	**A**	**SL.A**	**N.A**	**SL.D**	**D**	**S.D**
1	In most ways, my life is close to my ideal.							
2	The conditions of my life are excellent							
3	I am satisfied with my life							
4	So far I have gotten the important things I want in life							
5	If I could live my life over, I would change almost nothing							
S.A- Strongly agree, **A**-Agree, **SL.A**-Slightly agree, **N.A**-Neither agree nor disagree, **SL.D**-Slightly disagree, **D**-Disagree, **S.D**-Strongly disagree								

Research Tool 2:

Oxford happiness questionnaire was developed by psychologists Michael Argyle and Peter Hills (2002) at Oxford University. Below are a number of statements about happiness to indicate how much people agree or disagree. (Some of the questions are phrased positively and others negatively)

Table 3.10 Oxford Happiness Questionnaire

Sl. no	Questions		ST.D	MO.D	SL.D	SL.A	MO.A	ST.A
1	I don't feel particularly pleased with the way I am.	R						
2	I am intensely interested in other people.							
3	I feel that life is very rewarding.							
4	I have very warm feelings towards almost everyone.							
5	I rarely wake up feeling rested	R						
6	I am not particularly optimistic about the future.	R						
7	I find most things amusing							
8	I am always committed and involved.							
9	Life is good.							
10	I do not think that the world is a good place.	R						
11	I laugh a lot.							
12	I am well satisfied with everything in my life.							
13	I don't think I look attractive.	R						
14	There is a gap between what I would like to do and what I have done.	R						
15	I am very happy.							
16	I find beauty in some things.							
17	I always have a cheerful effect on others.							

18	I can fit in (find time for) everything I want to.							
19	I feel that I am not especially in control of my life.	R						
20	I feel able to take anything on.							
21	I feel fully mentally alert.							
22	I often experience joy and elation.							
23	I don't find it easy to make decisions.	R						
24	I don't have a particular sense of meaning and purpose in my life.	R						
25	I feel I have a great deal of energy.							
26	I usually have a good influence on events.							
27	I don't have fun with other people.	R						
28	I don't feel particularly healthy.	R						
29	I don't have particularly happy memories of the past	R						
Note: The R(Reverse scored) notation is related to mathematics at the end of the questions. **ST.D**-Strongly disagree-1, **MO.D**-Moderately disagree-2, **SL.D**-Slightly disagree-3, **SL.A**-Slightly agree-4, **MO.A**-Moderately agree-5, **ST. A**-Strongly agree-6.								

Step 1. Items marked (R) should be scored in reverse: For example, if you gave yourself a 1 cross it out and change it to a 6, Change 2 to a 5 Change 3 to a 4 Change 4 to a 3 Change 5 to a 2 Change 6 to a 1.

Step 2. Add the numbers for all 29 questions. (Use the converted numbers for the 12 items that are reverse scored.)

Step 3. Divide by 29. So your happiness score = the total (from step 2) divided by 29.

Research tool 3:

Table 3.11 Short form – 36 Health survey questionnaires

1	**In general, would you say your health is:**			
a)	Excellent			
b)	Very good			
c)	Good			
d)	Fair			
e)	Poor			
2	**Compared to one year ago, how would you rate your health in general now?**			
a)	Much better now than one year ago			
b)	Somewhat better now than one year ago			
c)	About the same			
d)	Somewhat worse now than one year ago			
e)	Much worse now than one year ago			
Does your health now limit you in activities? If so, how much?		**Yes, limited a lot**	**Yes, limited a little**	**No, not limited at all**
3	Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports			
4	Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf			
5	Lifting or carrying groceries			
Does your health now limit you in activities? If so, how much?		**Yes, limited a lot**	**Yes, limited a little**	**No, not limited at all**
6	Climbing several flights of stairs			
7	Climbing one flight of stairs			
8	Bending, kneeling or stooping			
9	Walking more than a mile			
10	Walking several blocks			
11	Walking one block			
12	Bathing or dressing yourself			
During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your **physical health**?				
13	Cut down the amount of time you spent on work or other activities		**Yes**	**No**

14	Accomplished less than you would like		
15	Were limited in the kind of work or other activities		
16	Had difficulty performing the work or other activities (for example, it took extra effort)		
During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any **emotional problems** (such as feeling depressed or anxious)?			
17	Cut down the amount of time you spent on work or other activities	**Yes**	**No**
18	Accomplished less than you would like		
19	Didn't do work or other activities as carefully as usual		

20	During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal **social activities** with family, friends, neighbours, or groups?		
a)	Not at all	d)	Quite a bit
b)	Slightly	e)	Extremely
c)	Moderately		
21	**How much bodily pain have you had during the past 4 weeks?**		
a)	None	d)	Moderately
b)	Very mild	e)	Severe
c)	Mild	f)	Very severe
22	During the past 4 weeks, how much did pain interfere with **your normal work**?		
a)	Not at all	d)	Quite a bit
b)	A little bit	e)	Extremely
c)	Moderately		

These questions are about how you feel and how things have been with you **during the past 4 weeks**

		All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
23	Did you feel full of pep?						
24	Have you been a very nervous person?						
25	Have you felt so down in the dumps that nothing could cheer you up?						
26	Have you felt calm and peaceful?						

27	Did you have a lot of energy?						
28	Have you felt downhearted and blue?						
29	Did you feel worn out?						
30	Have you been a happy person?						
31	Did you feel tired?						

32	During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities?		
a)	All of the time	d)	A little of the time
b)	Most of the time	e)	None of the time
c)	Some of the time		

How true or false is each of the following statements for you?		**Definitely true**	**Mostly true**	**Don't know**	**Mostly false**	**Definitely false**
33	I seem to get sick a little easier than other people					
34	I am as healthy as anybody I know					
35	I expect my health to get worse					
36	My health is excellent					

Secondary data were collected from district offices of Chennai, Kanchipuram, Vellore and Thiruvallur, Directory of Help Age India, list of homes for the aged in and around Chennai and from many websites. The authorities, in charge of the old age homes, were contacted and obtained prior permission before data collection. After obtaining consent, each person was interviewed.

3.7 Pilot study

The pilot study helped the investigator to equip with an understanding of the overall objective of the study, the research question and objective of each question in the questionnaire. The pilot study enabled easy and convenient elicitation of information from the representative sample. A sample number of 40 samples were selected so that successive requirements and modifications could be made with the

schedule before gathering data from the larger group of respondents. Mainly it was conducted to test the reliability and suitability of the interview schedule. On the basis of the pilot study, further options were added to several questions.

3.8 Statistical analysis

The data were analysed using SPSS Version 20 and the results were recorded as frequencies, means, average and p-values. Tables and figures were used for comprehensive viewing of the results. The ANOVA was used for categorical variables. A P-value of <0.05 was taken as the criteria of significance for all purposes. The information, thus, obtained was analysed according to the objectives of the study, coded and tabulated. The results have been presented in the form of numbers and percentages.

3.9 Significance of the Study

As the problem of the institutionalized elderly is concealed from the public eye, it is difficult to estimate its extent in society. Therefore, there is a great need to create awareness about the quality of life of elderly people living in old age homes. The violence within the family is becoming a serious threat to the institution of the family and is subverting its legitimate role of providing emotional security to all its members. This study is, therefore, important in bringing the crime into the limelight so that proper intervention could be made possible to make the family or old age home a safe place for the elderly people.

The knowledge that is generated through this study would enable the government and policymakers to allocate adequate resources to strategies that aim to deal with this issue and to enhance the welfare measures for the inmates who suffer from this problem. Further, this study would help the educationists to introduce gerontology as a compulsory subject for boys and girls in schools and colleges where they would be taught to give respect to the elderly people so that they would perform their roles effectively when they become adults.

The study has highlighted the fact that the issue of elderly in old age home must be addressed publicly and that the non-formal agents of support such as neighbours, friends and relatives must be encouraged to intervene on behalf of the

elderly in old age homes. This study, which provides data on the extent of the problem, is needed to convince both the public and the policymakers that elderly abuse is more widespread in modern society and is, in fact, a significant social problem.

Till today, to the best of the knowledge of the researcher, there is no study made on this subject in a sociological perspective in Tamilnadu. So, the present study is an important contribution to the field of gerontology. There are so many writings in the newspapers, debates in the public forums and in the mass media about the problems of the elderly people in old age homes. If the government wants to make a scheme or a policy to better the lives of the inmates in old age homes, then the present research will be very essential to frame suitable policy.

3.10 Limitations of the study

Study on the life satisfaction of the institutionalized elderly people is considered as 'sensitive' because it has the potential to bring memories that are emotionally disturbing and painful. The researcher also faced some difficulties while collecting data from the aged. Many of them had a hearing problem and found it difficult to understand the conversations. Many were emotionally upset. The researcher had to wait until they were consoled. Every aged person took a long time to answer the questions. In old age homes, some inmates refused to speak the truth about their experiences.

CHAPTER IV

Profile of old age homes in Tamilnadu

Introduction

This chapter consists of two sections. Section- 4.1 explains the profile of 20 old age homes and Section-4.2 highlights the list of old age homes in Chennai, Kanchipuram, Vellore and Thiruvallur districts.

Section-4.1: Profile of 20 old age homes

This section gives a description of the old age homes. They are followed;

a) The nature of accommodation,

b) Number of inmates

c) Hospital facilities

d) Availability of medical facilities

e) Number of management staffs

f) Entertainment facilities

g) Availability of balanced diet

h) Type of food items

i) Type of rooms

j) Features in dormitory/Room

k) Outside visit of inmates

l) Garden facilities and

m) Recreational activities.

Table 4.1 elaborates the nature of accommodations in old age homes. Three types of services are available in old age homes. Out of 20 homes, 9 were free service homes, 8 were paid homes and only 3 were free-cum-paid homes. Some homes (3) have established only for elderly women. But, majority of homes (17) admitted men and women inmates. 50% of homes (5) gave admission only to the elderly people (60+).

Table 4.1 Nature of accommodation

District	Old age homes	Type of service	Sub -category	Persons accepted
Chennai	OAH – 1	Free	Men & Women	Above 60 years
	OAH – 2	Free	Men & Women	Above 60 years
	OAH – 3	Paid	Men & Women	Above 50 years
	OAH – 4	Free-cum-Paid	Only for Women	Above 40 years
	OAH – 5	Paid	Men & Women	Above 40 years
Kanchee -puram	OAH – 6	Free	Men & Women	Above 60 years
	OAH – 7	Free-cum-Paid	Men & Women	Above 60 years
	OAH – 8	Paid	Men & Women	Above 40 years
	OAH – 9	Paid	Men & Women	Above 60 years
	OAH – 10	Paid	Men & Women	Above 40 years
Vellore	OAH – 11	Free	Men & Women	Above 60 years
	OAH – 12	Free	Men & Women	Above 60 years
	OAH –13	Free	Only for Women	Above 60 years
	OAH – 14	Free	Men & Women	Above 60 years
	OAH –15	Paid	Men & Women	Above 50 years
Thiruvallur	OAH –16	Free	Men & Women	Above 60 years
	OAH –17	Free-cum-Paid	Men & Women	Above 40 years
	OAH –18	Free	Only for Women	Above 50 years
	OAH –19	Paid	Men & Women	Above 50 years
	OAH – 20	Paid	Men & Women	Above 50 years

Table 4.2 Number of inmates

District	Old age homes	Interviewed inmates	Number of male inmates	Number of female inmates
Chennai	OAH – 1	84	18	66
	OAH – 2	81	16	65
	OAH – 3	40	12	28
	OAH – 4	30	0	30
	OAH – 5	27	8	19
Kanchee -puram	OAH – 6	49	12	37
	OAH – 7	15	6	9
	OAH – 8	38	17	21
	OAH – 9	32	12	20
	OAH – 10	26	5	21
Vellore	OAH – 11	38	4	34
	OAH – 12	24	2	22
	OAH –13	21	0	21
	OAH – 14	15	1	14
	OAH –15	36	9	27
Thiruvallur	OAH –16	62	24	38
	OAH –17	12	4	8
	OAH –18	6	0	6
	OAH –19	66	28	38
	OAH – 20	8	4	4

Table 4.2 shows the number of interviewed inmates. The total numbers of male inmates were 182, and female inmates were 528. Majority of inmates were interviewed from the Chennai district (36.9%).

Table 4.3 Hospital facilities

District	Old age homes	Hospital	Visiting doctors	Nurses	Monthly check up
Chennai	OAH – 1	Private	Available	Available	Available
	OAH – 2	Private	Available	Available	Available
	OAH – 3	Private	Unavailable	Unavailable	Unavailable
	OAH – 4	Private	Unavailable	Unavailable	Unavailable
	OAH – 5	Private	Unavailable	Unavailable	Unavailable
Kanchee -puram	OAH – 6	Government	Available	Available	Available
	OAH – 7	Government	Unavailable	Unavailable	Unavailable
	OAH – 8	Private	Available	Available	Available
	OAH – 9	Government	Available	Available	Available
	OAH – 10	Government	Unavailable	Unavailable	Unavailable
Vellore	OAH – 11	Government	Unavailable	Unavailable	Unavailable
	OAH – 12	Government	Unavailable	Unavailable	Unavailable
	OAH –13	Government	Unavailable	Unavailable	Unavailable
	OAH – 14	Government	Unavailable	Unavailable	Unavailable
	OAH –15	Private	Available	Available	Available
Thiru -vallur	OAH –16	Government	Available	Available	Available
	OAH –17	Government	Unavailable	Unavailable	Unavailable
	OAH –18	Government	Unavailable	Unavailable	Unavailable
	OAH –19	Private	Unavailable	Unavailable	Unavailable
	OAH – 20	Private	Unavailable	Unavailable	Unavailable

Table 4.3 illustrates the hospital facilities in and around old age homes. Out of 20 homes, 11 old age home's inmates were guided to go to the nearby government hospital. Majority of paid home inmates go to the private hospital for their treatment. In some homes (7), visiting doctors were available and they conduct a routine check-up to their inmates to analyse their health condition. Out of 20 homes, nurses were available

only in seven homes. Majority of free homes, conduct a monthly medical check-up to their inmates. But some paid homes were not organizing medical check-up to their inmates.

Table 4.4 Availability of Medical facilities

District	Old age homes	Ambulance	Intensive care unit	Medicines	Walker/ wheel chair
Chennai	OAH – 1	Not available	Not available	Available	Available
	OAH – 2	Not available	Not available	Available	Available
	OAH – 3	Not available	Not available	Not available	Not available
	OAH – 4	Not available	Not available	Available	Available
	OAH – 5	Not available	Not available	Not available	Not available
Kanchee -puram	OAH – 6	Not available	Not available	Available	Available
	OAH – 7	Not available	Not available	Not available	Not available
	OAH – 8	Not available	Not available	Available	Not available
	OAH – 9	Available	Not available	Available	Available
	OAH – 10	Not available	Not available	Not available	Not available
Vellore	OAH – 11	Not available	Not available	Available	Available
	OAH – 12	Not available	Not available	Not available	Not available
	OAH –13	Not available	Not available	Available	Available
	OAH – 14	Available	Not available	Not available	Not available
	OAH –15	Not available	Not available	Available	Available
Thiru -vallur	OAH –16	Available	Not available	Available	Available
	OAH –17	Not available	Not available	Not available	Not available
	OAH –18	Not available	Not available	Available	Not available
	OAH –19	Not available	Not available	Available	Available
	OAH – 20	Not available	Not available	Not available	Available

Table 4.4 elaborates the availability of medical facilities in the old age homes. Out of 20 homes, only three homes provide ambulance service to their inmates. Intensive care unit was not available in all (20) old age homes. In 11 homes, walkers /wheelchairs were available and in 12 homes medicines were available to their inmates for fever, cough, pains and etc.

Table 4.5 Management staffs

District	Old age homes	Office staffs	Attainder	House hold workers	Security
Chennai	OAH – 1	2	2	3	1
	OAH – 2	4	4	5	2
	OAH – 3	2	2	3	1
	OAH – 4	2	1	2	0
	OAH – 5	2	1	2	0
Kanchee -puram	OAH – 6	2	2	3	1
	OAH – 7	1	1	1	0
	OAH – 8	2	1	2	0
	OAH – 9	3	3	2	1
	OAH – 10	1	1	1	0
Vellore	OAH – 11	2	1	2	1
	OAH – 12	1	1	1	0
	OAH –13	2	2	2	2
	OAH – 14	1	0	1	0
	OAH –15	2	2	2	1
Thiru -vallur	OAH –16	3	3	3	2
	OAH –17	1	0	0	0
	OAH –18	1	0	0	0
	OAH –19	3	2	3	1
	OAH – 20	2	1	1	1

Table 4.5 describes the number of management staff in old age homes. Majority of homes (14) had got more than one office staff members in their homes. There was no attender in 3 homes and inmates used to do cooking and cleaning for themselves. Out of 20 homes, only 6 homes had more than 2 household workers. 9 homes had not got workers for security service.

Table 4.6 Entertainment facilities

District	Old age homes	Television	Radio	Newspaper
Chennai	OAH – 1	Available	Available	Available
	OAH – 2	Available	Available	Available
	OAH – 3	Available	Not available	Available
	OAH – 4	Available	Not available	Available
	OAH – 5	Available	Not available	Available
Kanchee -puram	OAH – 6	Available	Not available	Available
	OAH – 7	Available	Not available	Not available
	OAH – 8	Available	Not available	Not available
	OAH – 9	Available	Available	Available
	OAH – 10	Available	Not available	Available
Vellore	OAH – 11	Available	Available	Available
	OAH – 12	Available	Not available	Available
	OAH –13	Available	Not available	Available
	OAH – 14	Available	Not available	Available
	OAH –15	Available	Not available	Available
Thiru -vallur	OAH –16	Available	Available	Available
	OAH –17	Available	Not available	Available
	OAH –18	Not available	Not available	Not available
	OAH –19	Not available	Not available	Not available
	OAH – 20	Available	Not available	Available

Table 4.6 shows the availability of entertainment facilities in old age homes. Out of 20 homes, 18 homes had got television and 2 homes did not have television. Radio was available in 15 homes. Majority of homes (14) provided newspaper to their inmates. Newspaper was the main entertainment of the male inmates and television serials and movies were the main entertainment of the female inmates.

Table 4.7 illustrates the availability of the type of foods in old age homes. Majority of old age homes (14) provide vegetarian food to their inmates and 6 homes provide vegetarian and non-vegetarian foods. Some paid homes allowed inmates to buy

non-vegetarian food from outside. Out of 20 homes, 10 homes provide evening snacks to their inmates. Mineral water was available in 15 homes. Due to poor economic conditions, five homes provide metro water to their inmates. 10 homes (50%) provide balanced diet to their inmates.

Table 4.7 Availability of balanced diet

District	Old age homes	Type of food	Evening snacks	Sources of drinking water	Balanced diet
Chennai	OAH – 1	Vegetarian	Available	Mineral water	Available
	OAH – 2	Vegetarian & Non-vegetarian	Available	Mineral water	Available
	OAH – 3	Vegetarian	Not Available	Mineral water	Not Available
	OAH – 4	Vegetarian	Not Available	Mineral water	Not Available
	OAH – 5	Vegetarian & Non-vegetarian	Not Available	Mineral water	Not Available
Kanchee -puram	OAH – 6	Vegetarian	Available	Mineral water	Available
	OAH – 7	Vegetarian	Not Available	Metro water	Not Available
	OAH – 8	Vegetarian & Non-vegetarian	Not Available	Mineral water	Not Available
	OAH – 9	Vegetarian	Not Available	Mineral water	Available
	OAH – 10	Vegetarian	Not Available	Metro water	Not Available
Vellore	OAH – 11	Vegetarian & Non-vegetarian	Available	Mineral water	Available
	OAH – 12	Vegetarian	Not Available	Mineral water	Not Available
	OAH –13	Vegetarian & Non-vegetarian	Not Available	Mineral water	Available
	OAH – 14	Vegetarian	Not Available	Metro water	Not Available
	OAH –15	Vegetarian & Non-vegetarian	Available	Mineral water	Available
Thiru -vallur	OAH –16	Vegetarian	Available	Mineral water	Available
	OAH –17	Vegetarian	Not Available	Metro water	Not Available
	OAH –18	Vegetarian	Not Available	Metro water	Not Available
	OAH –19	Vegetarian	Available	Mineral water	Available
	OAH – 20	Vegetarian	Not Available	Mineral water	Available

Table 4.8 Food items

District	Old age homes	Fruits	Vegetables	Dal/grains	Milk/curd
Chennai	OAH – 1	Available	Available	Available	Available
	OAH – 2	Available	Available	Available	Available
	OAH – 3	Not available	Available	Available	Available
	OAH – 4	Not available	Available	Available	Available
	OAH – 5	Not available	Available	Available	Available
Kanchee -puram	OAH – 6	Available	Available	Available	Available
	OAH – 7	Not available	Available	Available	Available
	OAH – 8	Not available	Available	Available	Available
	OAH – 9	Not available	Available	Available	Available
	OAH – 10	Not available	Available	Available	Available
Vellore	OAH – 11	Available	Available	Available	Available
	OAH – 12	Not available	Available	Available	Available
	OAH –13	Not available	Available	Available	Available
	OAH – 14	Not available	Available	Available	Available
	OAH –15	Not available	Available	Available	Available
Thiru -vallur	OAH –16	Not available	Available	Available	Available
	OAH –17	Not available	Available	Available	Available
	OAH –18	Not available	Available	Available	Available
	OAH –19	Not available	Available	Available	Available
	OAH – 20	Not available	Available	Available	Available

Table 4.8 shows the availability of food items in old age homes. Majority of homes (16) could not provide fruits to their inmates. Some paid home inmates buy the fruits separately from outside of the home. All the homes (20) provide vegetables, grams and milk to their inmates. On the whole, 50% of homes (10) provide a balanced diet (Table 4.7) to their inmates based on their economic condition.

Table 4.9 highlights the availability of rooms in 20 old age homes. Majority of homes (14) had got a common hall, worship place (12) and storeroom (12). Only nine homes had got a dining hall facility.

Table 4.9 Availability of Rooms

District	Old age homes	Common hall	Dining hall	Worship place	Store room
Chennai	OAH – 1	Available	Available	Available	Available
	OAH – 2	Available	Available	Available	Available
	OAH – 3	Available	Not available	Available	Available
	OAH – 4	Available	Not available	Not available	Not available
	OAH – 5	Available	Not available	Not available	Not available
Kanchee -puram	OAH – 6	Available	Not available	Available	Available
	OAH – 7	Available	Not available	Not available	Not available
	OAH – 8	Available	Available	Not available	Available
	OAH – 9	Available	Available	Available	Available
	OAH – 10	Not available	Not available	Available	Not available
Vellore	OAH – 11	Available	Available	Available	Available
	OAH – 12	Available	Not available	Not available	Not available
	OAH –13	Not available	Available	Available	Available
	OAH – 14	Not available	Not available	Not available	Not available
	OAH –15	Available	Available	Available	Available
Thiru -vallur	OAH –16	Not available	Available	Available	Available
	OAH –17	Not available	Not available	Not available	Not available
	OAH –18	Not available	Not available	Not available	Not available
	OAH –19	Available	Available	Available	Available
	OAH – 20	Available	Not available	Available	Available

Table 4.10 Room features

District	Old age homes	Attached rest room	Call button	Self-cooking in room	Fire extin -guisher
Chennai	OAH – 1	Available	Not available	Not available	Available
	OAH – 2	Available	Not available	Not available	Available
	OAH – 3	Available	Not available	Available	Available
	OAH – 4	Not available	Not available	Not available	Not available
	OAH – 5	Not available	Not available	Not available	Not available
Kanchee -puram	OAH – 6	Not available	Not available	Not available	Not available
	OAH – 7	Not available	Not available	Not available	Not available
	OAH – 8	Available	Not available	Available	Available
	OAH – 9	Not available	Not available	Not available	Available
	OAH – 10	Not available	Not available	Not available	Not available
Vellore	OAH – 11	Not available	Not available	Not available	Available
	OAH – 12	Not available	Not available	Not available	Not available
	OAH –13	Not available	Not available	Not available	Not available
	OAH – 14	Not available	Not available	Not available	Not available
	OAH –15	Available	Not available	Not available	Available
Thiru -vallur	OAH –16	Available	Not available	Not available	Available
	OAH –17	Not available	Not available	Not available	Not available
	OAH –18	Not available	Not available	Not available	Not available
	OAH –19	Available	Not available	Not available	Available
	OAH – 20	Available	Available	Not available	Available

Table 4.10 describes the special room features of old age homes. Out of 20 homes, 8 homes had got attached restroom facility. Only one paid home arranged call button facility in the bedroom of inmates. 2 paid homes allow their inmates to cook in their room. The fire extinguisher was available in 10 homes.

Table 4.11 Features of old age home (1)

District	Old age homes	Visit of relatives	Outside visit of inmates	Night time nurses	Exercise facilities
Chennai	OAH – 1	Allow	Allow	Not available	Available
	OAH – 2	Allow	Allow	Available	Available
	OAH – 3	Allow	Allow	Not available	Not available
	OAH – 4	Allow	Allow	Not available	Not available
	OAH – 5	Allow	Not allow	Not available	Not available
Kanchee -puram	OAH – 6	Allow	Not allow	Not available	Not available
	OAH – 7	Allow	Allow	Not available	Not available
	OAH – 8	Allow	Not allow	Not available	Not available
	OAH – 9	Allow	Not allow	Not available	Not available
	OAH – 10	Allow	Allow	Not available	Not available
Vellore	OAH – 11	Not allow	Not allow	Not available	Not available
	OAH – 12	Not allow	Allow	Not available	Not available
	OAH –13	Not allow	Not allow	Not available	Not available
	OAH – 14	Allow	Allow	Not available	Not available
	OAH –15	Allow	Not allow	Not available	Not available
Thiru -vallur	OAH –16	Not allow	Not allow	Not available	Not available
	OAH –17	Allow	Allow	Not available	Not available
	OAH –18	Allow	Allow	Not available	Not available
	OAH –19	Allow	Allow	Not available	Not available
	OAH – 20	Allow	Allow	Not available	Not available

Table 4.11 explains the outside visit of inmates. Out of 20 homes, the majority of homes (16) accepted the relatives/friends to visit the inmates in the homes. 12 homes allowed the inmates to go outside, to buy things and visit the relatives with prior permission from the management. In one home, nurses were available in night-time services. And two homes motivated their inmates to do exercises regularly.

Table 4.12 Features of old age home (2)

District	Old age homes	Medical facilities	Dustbin in room	Garden	Telephone
Chennai	OAH – 1	Available	Available	Available	Available
	OAH – 2	Available	Available	Available	Available
	OAH – 3	Available	Available	Available	Available
	OAH – 4	Available	Not available	Available	Available
	OAH – 5	Available	Available	Not available	Not available
Kanchee -puram	OAH – 6	Available	Available	Not available	Not available
	OAH – 7	Available	Available	Available	Available
	OAH – 8	Not available	Available	Not available	Not available
	OAH – 9	Available	Available	Available	Available
	OAH – 10	Not available	Not available	Not available	Not available
Vellore	OAH – 11	Available	Available	Available	Available
	OAH – 12	Available	Not available	Not available	Available
	OAH –13	Available	Not available	Available	Not available
	OAH – 14	Not available	Not available	Available	Available
	OAH –15	Available	Available	Available	Available
Thiru -vallur	OAH –16	Available	Available	Available	Not available
	OAH –17	Not available	Not available	Available	Not available
	OAH –18	Available	Not available	Available	Not available
	OAH –19	Available	Available	Available	Available
	OAH – 20	Available	Available	Available	Available

Table 4.12 illustrates the special features of old age homes. Majority of old age homes (16) had got medical facilities. 15 homes had got garden in their homes. The telephone was available in 12 homes and paid home inmates had got their own mobiles. In some paid homes, dustbin was available in the room of the inmates.

Table 4.13 elaborates the recreational and social activities of inmates. Out of 20 homes, 8 homes organize social activities for inmates. They celebrate religious festivals that are Christmas, New Year, Pongal and Diwali. Some homes celebrate the

birthday of their inmates. Recreational activities are also organized by some old age homes (5) that are singing programs, rangoli and cooking competition. Yearly once they go outside for one day picnic. In festival time, they arrange programs and invite the school and college students to participate in the programs. Social and recreational activities take place a vital role in the quality of life of inmates. It gives psychological support, develops the health status and reduces the negative feeling of inmates.

Table 4.13 Activities of inmates

District	Old age homes	Social activity	Recreational activity
Chennai	OAH – 1	Available	Available
	OAH – 2	Available	Available
	OAH – 3	Not available	Not available
	OAH – 4	Not available	Not available
	OAH – 5	Not available	Not available
Kanchee -puram	OAH – 6	Not available	Not available
	OAH – 7	Not available	Not available
	OAH – 8	Not available	Not available
	OAH – 9	Available	Not available
	OAH – 10	Not available	Not available
Vellore	OAH – 11	Available	Available
	OAH – 12	Not available	Not available
	OAH –13	Available	Available
	OAH – 14	Not available	Not available
	OAH –15	Available	Not available
Thiruvallur	OAH –16	Available	Available
	OAH –17	Not available	Not available
	OAH –18	Not available	Not available
	OAH –19	Available	Not available
	OAH – 20	Not available	Not available

Section 4.2 List of old age homes

Table 4.2.1 List of old age homes in Chennai district

Sl.no	Old age homes	Area
1	Aatharavu home (Men)	Iyyapanthangal
2	Aatharavu home (women)	Pallikaranai
3	Aathmaalayam	Velachery
4	Abhisri old age home	Ambattur estate
5	Adaikalam	Mogappair west
6	Adarsh home for the aged women	Royapettah
7	Ahobilam senior citizen home	Velachery
8	Anandam free home for senior citizens	Ambattur
9	Anbagam CSI Home for the aged	Adyar
10	Anbalayam (YMCA)	Poonamalle high road
11	Anbu karangal	Palavakkam
12	Anna anandha illam	Ambattur
13	Annai illam	Karapakkam
14	Annai illam	Ramapuram
15	Arunodhaya	Thirumullaivoyal
16	Aruwe	Ayanavaram
17	Ashirwadh care home	Injambakkam
18	Ashram	Porur
19	Ashram foundation	Maduravoyal
20	Ashram seniors	Porur
21	Asian helps foundation	Porur
22	Athmaalayam senior citizen home	Velachery
23	AUMSSS	Anna Nagar West
24	Beatitudes social welfare centre	Vyasarpadi
25	Birds nest OAH Unit 2	Thiruverkadu
26	Brindavanam	Allapakam
27	Captain Lingam old age home	Saligramam
28	Centre for the welfare of the aged	Virugambakkam
29	Charles elders community	Kathirvedu
30	Charus home for aged	T.Nagar
31	Chellammal srinivasa iyer mudhiyor illam	Adambakkam
32	Chennai lions charitable trust	T.Nagar
33	Classic kudumbam	Solinganallur
34	Cornerstone senior services	vettuvankanni
35	Devaki senior citizen home	Vettuvankani

Sl.no	Old age homes	Area
36	Dharani illam	Mugalivakkam
37	Dhayakendra old age home	Purasaiwalkam
38	Don Bosco old age home	St Thomas Mount
39	Elders paradise	Thiruvanmiyur
40	Fathima trust	Thorappakkam
41	Friend-in-need society	Parktown
42	Friends for the needy	Thirumullaivoyal
43	G.S senior citizens home	T.Nagar
44	Ganesa sankari home	Madambakkam
45	Garden elder care centre	Madampakkam
46	Gladden foundation	Avadi
47	Gold age hospital Pvt.ltd	Porur
48	Grace home for aged	St Thomas Mount
49	Gracious home	Annanagar
50	Happy home	Perambur
51	Hephzibah- Home for the aged	K.K.Nagar
52	Hepzibah trust	Nesapakkam
53	Home happy home	perambur
54	Idhaya vaasal elders home	Pallikaranai
55	Indian council for social welfare	Kilpauk
56	Indira charitable trust	Injambakkam
57	Iraiyanbu illam	Kolathur
58	J.C Guardian aged home	Madhavaram
59	Jeeva Jothi illam	Redhills
60	Jeevan care centre and OAH	Ayanavaram
61	Jesus the way trust	T Nagar
62	John bosco care home	Ramapuram
63	JP Home for the aged	Madhavaram
64	K.J Home for the aged	Chetpet
65	Kakkum karangal	Santhome
66	Kalaiselvi karunalaya SWS	Mogappair west
67	Kamarajar old age home	Porur
68	Kanivu karangal	Manali
69	Karunai illam	Villivakkam
70	Karunai illam	Little mount
71	Karunai villa trust old age home	Porur
72	Kumaran charitable trust for the aged	Pattabiram
73	Little drops	Porur

Sl.no	Old age homes	Area
74	Little sister of the poor	Chetpet
75	Lucky thai illam	Porur
76	Mahalakshmi foundation	Avadi
77	Mahalakshmi old age home	Nanganallur
78	Mahatma senior citizen home	Jawaharnagar
79	Manitha neyam old age home	Hasthinapuram
80	Manogar& raja of venkatagiri choultries	Washermenpet
81	Maria's old age home	St Thomas Mount
82	Mary Rebecca annai old age home	Perambur
83	Mass aged care home	Vivekananda nagar
84	Melur meadows alternative life style	Ashok nagar
85	Mercy home	Kilpauk
86	Missionaries of charity	Chetpet
87	Mother's old age home	Madipakkam
88	MSPC senior citizen home	Old washermenpet
89	Nambikkai old age home	Thirumullaivoyal
90	Nandhi senior citizen home	Neelangarai
91	Narbavi senior citizen home for women	Sholinganallur
92	National council of women in India	R.A Puram
93	Nava Jothi charitable trust	R.A Puram
94	Om shanthi old age home	Kilpauk
95	Oxford home for the aged	Oorapakkam
96	Paasam	Thiruvetriyur
97	Parisutha narkarunai illam	Avadi
98	Perundevi old age home	Keelkattalai
99	Pope john's garden old age home	Madhavaram
100	Prasanthi home	Perungudi
101	Prasanthi home for senior citizen	Adambakkam
102	Prasanthi old age welfare home	Perungudi
103	Preetham old age home	Jawaharnagar
104	R V K Home for aged	Mogappair west
105	Rajanikanth old age home	Selaiyur
106	Rishi Aalayam	Periyar Nagar
107	S.V Home for the aged	Arumbakkam
108	Sahayaillam for the aged	St. Thomas mount
109	Sai old age home	Kundrathur
110	Sai saran senior citizen home	Solinganallur
111	Saraswathi ammal charitable trust	Korattur

Sl.no	Old age homes	Area
112	Sathiyameh jayam charitable trust	Nesapakkam
113	Sathyalok home for senior citizens	Porur
114	Sathyameh jayam charitable trust	Keelkattalai
115	Savithri ammaiyar senior citizen home	Injambakkam
116	Sea breeze old age home	Thoraipakkam
117	Senior citizen home for women	Royapettah
118	Sevalaya old age home	Thiruvanmiyur
119	Seva samaj, meals on wheels	Egmore
120	Shanthi Sadhan	Chetpet
121	Shiridi home care	Madipakkam
122	Sneha sadan senior citizen's home	Vanagaram
123	Sneham senior citizen home	Virugambakkam
124	Sondham old age home	Pattabiram
125	Sree seva mandir	Virugambakkam
126	Sri Aishwarya old age home	Koyambedu
127	Sri arupadayan homes	Keelkattalai
128	Sri Guru Ragavendra old age home	Ullagaram
129	Sri padmavathi amma OAH	Mangadu
130	Sri perundevi thayar senior citizen home	Thiruvanmiyur
131	Sri poorna Mahameru Trust	Old pallavaram
132	Sri ram old age home	Besant nagar
133	Sri sankara home for the senior citizens	Thiruvanmiyur
134	Sri Vidhya senior citizen	K.K.Nagar
135	Sri vigneshwara old age home	Palkalai nagar
136	Sri vinayaga OAH	K K Nagar
137	Sri.P.Obul Reddy senior citizen home	R.A Puram
138	St. Thomas home for the aged	Vyasarpadi
139	Thayagam	Porur
140	Trinity happy home	Vepery
141	Udavumkarangal	NSK Nagar
142	Universal karunalayam	Nandanam
143	Uthavum Ethayangal old age home	Saidapet
144	Valli old age home	Kundrathur
145	VHS senior citizen centre	Adyar
146	Vigneswara old age home	Palavakkam
147	Vishranthi home for the destitute women	Palavakkam
148	Vivegam mudhiyor illam	Velachery
149	Vuyiroli old age home	Kilpauk

Sl.no	Old age homes	Area
150	War widows welfare association	R.A Puram
151	Wellness communes Pvt. ltd	Gopalapuram
152	YMCA Home for the aged	Vepery

Table 4.2.2 List of old age homes in Kanchipuram district

Sl.no	Old age home	Area
1	Kaikoduppom charitable trust	Kovilambakkam
2	Shree hari old age home	Guduvancherry
3	Captain lingam welfare trust	Urapakkam
4	Annai terasa aged home	Mamallapuram
5	Amazing love home	manimangalam
6	Amma appa old age home	Vandalur
7	Paradise old age home	Vandalur
8	Oxford home for aged	Chengalpat
9	Kumaran charitable trust	Pattabiram
10	Adaikalam	Pattabiram
11	Sri vari charitable trust	Singaperumalkoil
12	Parimala padmanaban OAH	Potheri
13	Anbu karangal	Chengalpet
14	Bird OAH	Melmaruvathur
15	Karnal pennikuk charitable trust	Chengalpet
16	Abode of joy	Guduvancherry
17	Vishranthi charitable trust	Sriperumbudur
18	Sivananda saraswathi sevashram	Kattankolathur
19	Amaithi old age home	Madambakkam
20	Amma appa old age home	Mudichur
21	Nandhavanam	Koyambakkam
22	Srimathi sundaravalli memorial residency for senior citizen	Puthur
23	Manolayam seniors home	Sirukalathur
24	Gokulam	Sriperumbudur
25	Anbu thondu nilayam	Chengalpet
26	Sukhalaya R R S Trust	Tambaram
27	M M D Old age home	Madambakkam
28	Sami old age home	Madambakkam
29	Ganesa sankari home	Chengalpet
30	Idhaya vaasal elder’s home	Pallikaranai
31	Namrutha old age home	Tambaram

Sl.no	Old age homes	Area
32	Trinity home	Tambaram
33	Akshaya trust	Mudichur
34	Arokkiyam gold age home	Tambaram
35	New life charitable trust	Sriperumbudur
36	Sri mangalambiga OAH	Mudichur

Table 4.2.3 List of old age homes in Vellore district

Sl.no	Old age home	Area
1	Vivekanandar trust	Sathuvachari
2	Jayam charitable trust	Katpadi
3	Velicham trust	Anaicut
4	Annai charitable trust	Melmonavoor
5	Florence nightingale trust	Walajapet
6	Clara old age home	Gandhi nagar
7	St joseph's home for the aged	Katpadi
8	St anne's home for the aged	Gudiyatham
9	Poondi mahan mudhiyor illam	Vanjur
10	Vallalar mudhiyor illam	Velapadi
11	Indian red cross society	Poigai
12	Nirmal hriday old age home	Shenbakkam
13	M B K G Pannai	Kasam
14	Aathma shanthi OAH	Katpadi

Table 4.2.4 List of old age homes in Thiruvallur district

Sl. no	Old age home	Area
1	Sevalaya	Thiruninravur
2	Kokilam balakrishnan OAH	Thiruvallur
3	Thaayin koodu OAH	Priyankuppam
4	Rajajie elders security trust	Aranvoyal village
5	Kumaran charitable trust	Pattabiram
6	Susheelamma OAH	Kosavan palayam
7	Adaikalam	Pattabiram
8	Anugraha old age home	Thiruninravur
9	Word of holy god mission	Avadi
10	Home sweet home	Nathammedu
11	Sondham old age home	Pattabiram

CHAPTER V

Analysis of the Socio-Economic Condition of Inmates

5.1 Distribution of inmates

Researches in social sciences are empirical in nature and based on the respondents perceptions of socio-economic conditions. Their perceptions are influenced by various socio-economic factors. It is necessary to understand the socio-economic condition of respondents in sociological studies. This chapter deals with socio-economic background of inmates with special reference to four districts in Tamilnadu. Before analysing the life satisfaction of inmates; the socio-economic, demographic and cultural characteristics of the inmates have been identified on the basis of sample collected for the study.

The socio-economic conditions play an important role in characterizing the social life and behaviour of an individual. The socio -economic status of an individual affects the patterns of interaction in the society. It is therefore essential to analyse the socio-economic background of the respondents to understand the lifestyle of the respondents. Knowledge of socio-economic background of a community is an indispensable prerequisite, for the understanding of the thought or behaviour of its members. The major factors include age, religion, marital status, family background, education, and control on economic activities, economic status and occupation. Social role of a person and his contribution to the society is based on his socio-economic background. Distribution of inmates on various socio economic factors, are followed;

Table 5.1: **District wise distribution of inmates**

District	Number of old age homes	Total Number of inmates	
		N	%
Chennai	5	262	36.9
Kancheepuram	5	160	22.5
Vellore	5	134	18.9
Thiruvallur	5	154	21.7
Total	**20**	**710**	**100**

Table 5.1 shows the number of old age homes and the number of inmates interviewed from four districts of Tamilnadu. According to the census 2011, the first four highly populated districts from Tamilnadu were selected for this research work. From each district, five old age homes were interviewed.

In Chennai, a major percentage (36.9%) of 262 inmates was interviewed. From Kancheepuram 160 inmates (22.5%), Thiruvallur 154 inmates (21.7%) and from Vellore 134 inmates (18.9%) were interviewed.

Chart 5.1: **District wise distribution of inmates**

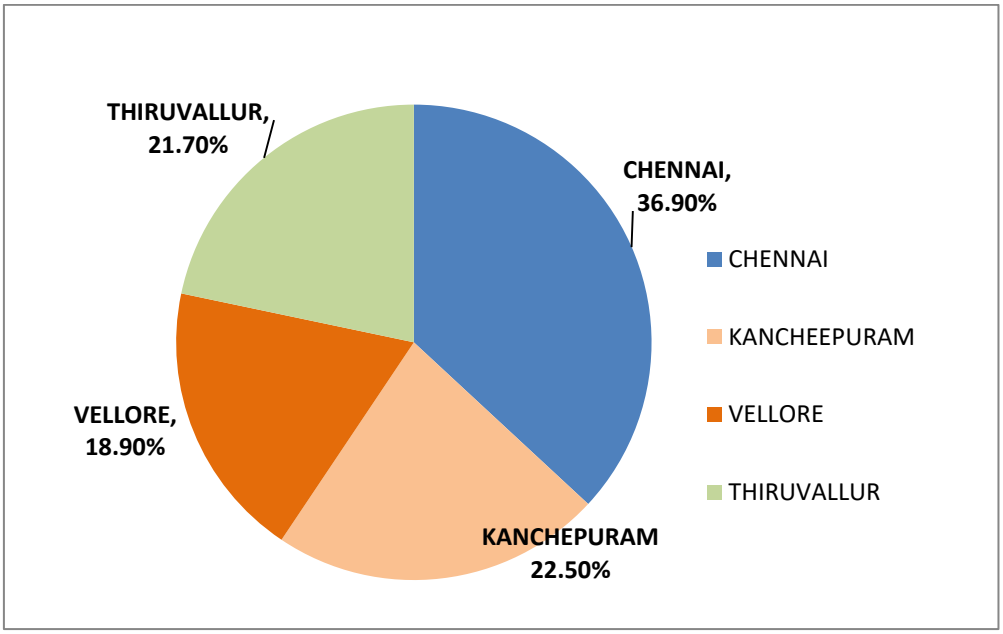


Table 5.2 reveals that out of 20 homes, nearly three fourth of inmates (74.4%) were females (262) and only one-fourth of inmates (25.6%) were males (182). It was found that the majority of inmates (84) were interviewed from OAH-1. Only 6 inmates were interviewed from OAH-18 and all of them in that home were females.

The highest number of male inmates (28) was interviewed from OAH-19 and highest number of female inmates (66) was interviewed from OAH-1. The minimum number of male (4) and female (4) were interviewed in OAH-20 from Thiruvallur district.

Out of 20 old age homes, three homes were run only for women inmates. They are OAH-4, OAH-13 and OAH-18.

Table 5.2 Gender wise distribution of inmates in old age homes

District	Name of the old age homes (OAH)	Male		Female		Total
		N	%	N	%	N
Chennai	OAH-1	18	21.4	66	78.6	84
	OAH-2	16	19.8	65	80.2	81
	OAH-3	12	30.0	28	70.0	40
	OAH-4	0	0.0	30	100	30
	OAH-5	8	29.6	19	70.4	27
	Total	**54**	**20.6**	**208**	**79.4**	**262**
Kanchee-puram	OAH-6	12	24.5	37	75.5	49
	OAH-7	6	40.0	9	60.0	15
	OAH-8	17	44.7	21	55.3	38
	OAH-9	12	37.5	20	62.5	32
	OAH-10	5	19.2	21	80.8	26
	Total	**52**	**32.5**	**108**	**67.5**	**160**
Vellore	OAH-11	4	10.5	34	89.5	38
	OAH-12	2	8.3	22	91.7	24
	OAH-13	0	0.0	21	100	21
	OAH-14	1	6.7	14	93.3	15
	OAH-15	9	25.0	27	75.0	36
	Total	**16**	**11.9**	**118**	**88.1**	**134**
Thiru-vallur	OAH-16	24	38.7	38	61.3	62
	OAH-17	4	33.3	8	66.7	12
	OAH-18	0	0.0	6	100	6
	OAH-19	28	42.4	38	57.6	66
	OAH-20	4	50.0	4	50.0	8
	Total	**60**	**39.0**	**94**	**61.0**	**154**
Total		**182**	**25.6**	**528**	**74.4**	**710**

Note: OAH - old age home

Chart 5.2 Gender wise distributions of inmates in 20 homes

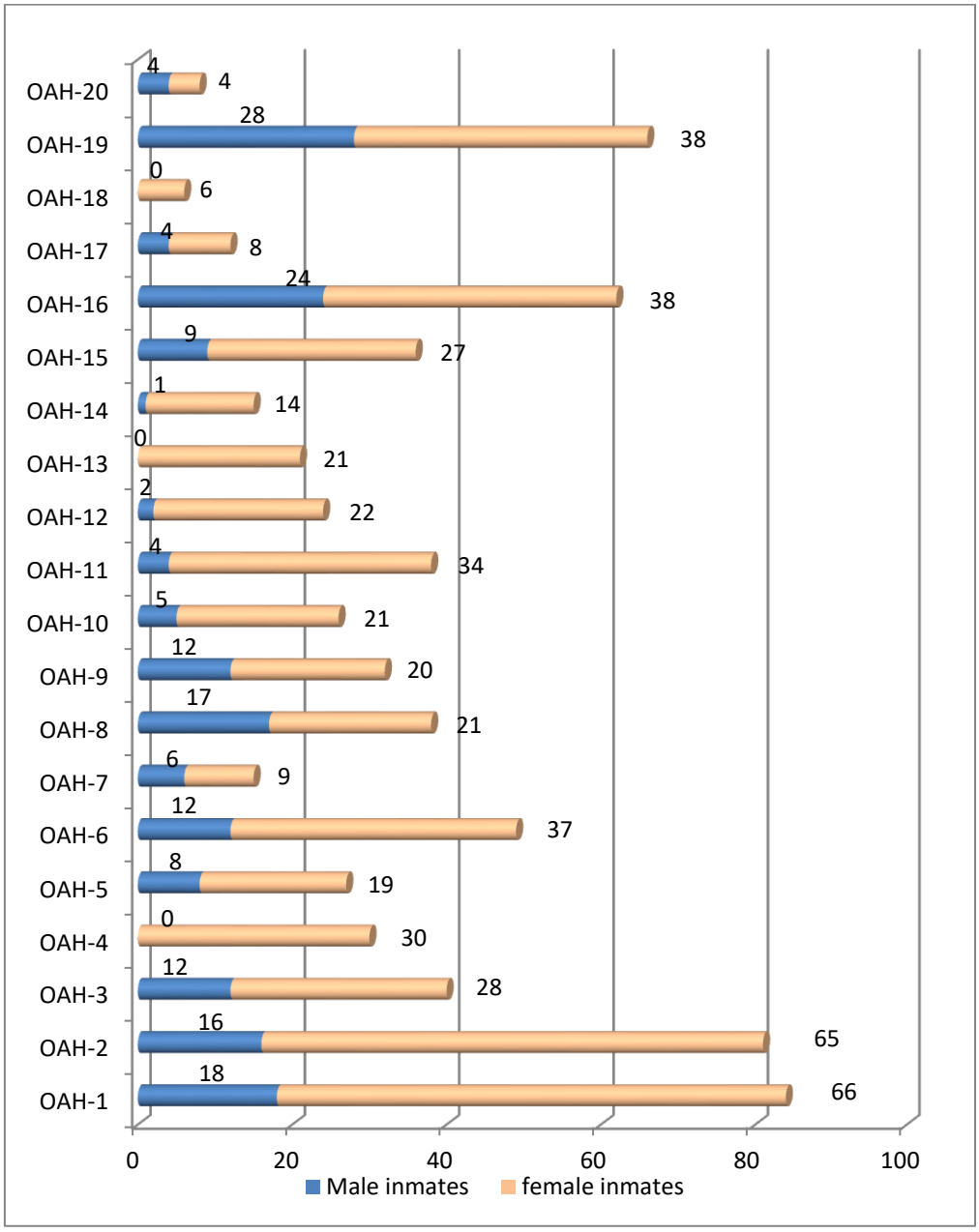
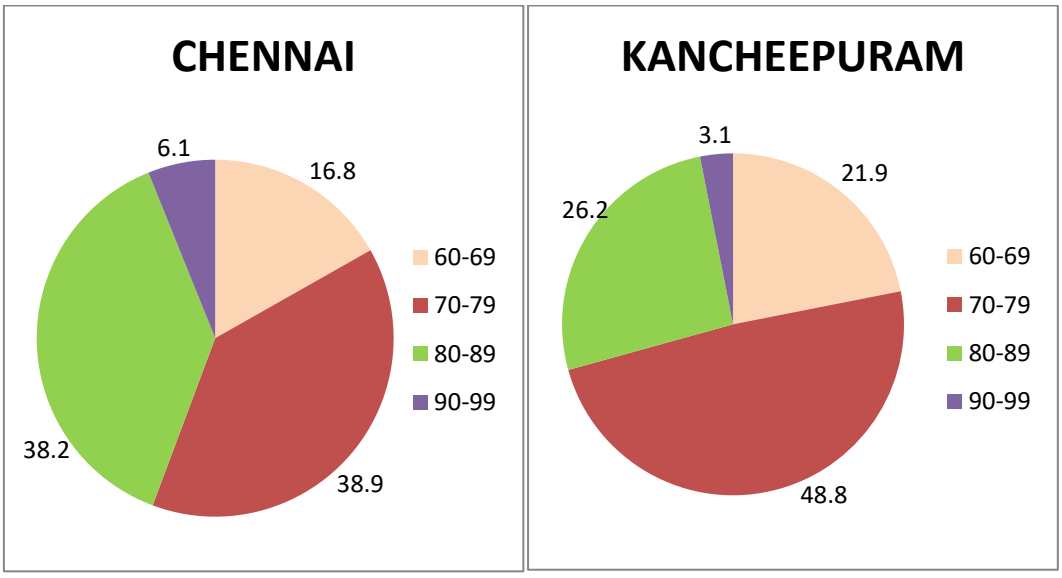


Table 5.3 shows the age-wise distribution of inmates in four districts. It was found that (307) majority of inmates (43.2%) belonged to the age group of 70 to 79 years, 244 inmates (17.9%) were in the age group of 80 to 89 years, 127 inmates (17.9%) were in the age group of 60 to 69 years and 32 inmates (4.5%) were in the age group of 90 to 99 years. A closer look to the table reveals that the percentage of males as compared with the females are less since male inmates' life span is generally short for they succumb to many heart diseases and risk in life. The highest percentage of male and female in the age group of 90 to 99 years were residing in Chennai district.

Table 5.3 Age-wise distribution of inmates

District	Gender	Age - group of inmates								Total
		60-69		70-79		80-89		90-99		
		N	%	N	%	N	%	N	%	N
Chennai	Male	9	16.7	21	38.9	21	38.9	3	5.6	54
	Female	35	16.8	81	38.9	79	38.0	13	6.2	208
	Total	44	16.8	102	38.9	100	38.2	16	6.1	**262**
Kanche epuram	Male	14	26.9	24	46.2	14	26.9	0	0.0	52
	Female	21	19.4	54	50.0	28	25.9	5	4.6	108
	Total	35	21.9	78	48.8	42	26.2	5	3.1	**160**
Vellore	Male	1	6.2	6	37.5	9	56.2	0	0.0	16
	Female	17	14.4	40	33.9	56	47.5	5	4.2	118
	Total	18	13.4	46	34.3	65	48.5	5	3.7	**134**
Thiru -vallur	Male	11	18.3	33	55.0	13	21.7	3	5.0	60
	Female	19	20.2	48	51.1	24	25.5	3	3.2	94
	Total	30	19.5	81	52.6	37	24.0	6	3.9	**154**
Total	Male	35	19.2	84	46.2	57	31.3	6	3.3	182
	Female	92	17.4	223	42.2	187	35.4	26	4.9	528
	Total	**127**	**17.9**	**307**	**43.2**	**244**	**34.4**	**32**	**4.5**	**710**

Chart 5.3 Age-wise distribution of inmates



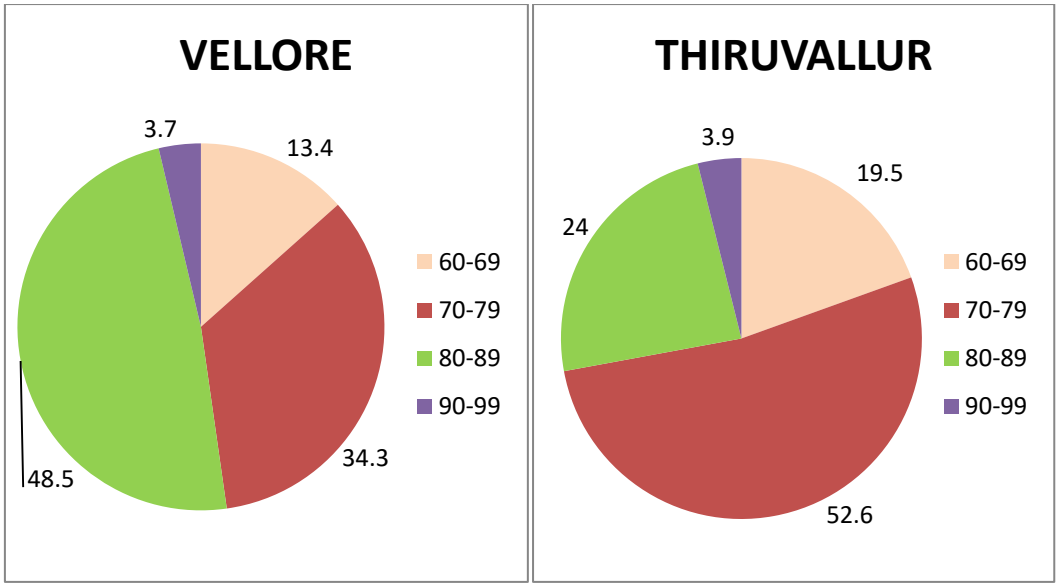


Table 5.4 Types of Old age homes

District	Old Age Homes (OAH)	Types of Old age homes			Total
		Free	Paid	Free cum Paid	
Chennai	OAH 1	✔			
	OAH 2	✔			
	OAH 3		✔		
	OAH 4			✔	
	OAH 5		✔		
	Total	**2**	**2**	**1**	**5**
Kanchee -puram	OAH 6	✔			
	OAH 7			✔	
	OAH 8		✔		
	OAH 9		✔		
	OAH 10		✔		
	Total	**1**	**3**	**1**	**5**
Vellore	OAH 11	✔			
	OAH 12	✔			
	OAH 13	✔			
	OAH 14	✔			
	OAH 15		✔		
	Total	**4**	**1**	**0**	**5**
Thiru -vallur	OAH 16	✔			
	OAH 17			✔	
	OAH 18	✔			
	OAH 19		✔		
	OAH 20		✔		
	Total	**2**	**2**	**1**	**5**
Total		9	8	3	20

Table 5.4 shows the number of Free homes, Paid homes and Free- cum-Paid homes included in this research work. Out of 20 old age homes, 9 were Free homes, 8 were Paid homes and 3 were Free-cum-Paid homes. Majority of (4) free homes were interviewed in Vellore district. 3 paid homes were interviewed in Kancheepuram district. In all the districts free homes and paid homes were more in number. But free-cum-paid homes were less in number. Luxuries paid homes were seen in Kancheepuram district.

5.2 Family background of inmates

Table 5.5 Marital Status of inmates

District	Marital status					Total
	Single	**Married**	**Widowed**	**Separated**	**Divorces**	
Chennai	94 35.9%	13 5.0%	147 56.1%	6 2.3%	2 0.8%	262 100.0%
Kanchepuram	60 37.5%	8 5.0%	82 51.2%	10 6.2%	0 0.0%	160 100.0%
Vellore	48 35.8%	9 6.7%	75 56.0%	2 1.5%	0 0.0%	134 100.0%
Thiruvallur	50 32.5%	22 14.3%	79 51.3%	2 1.3%	1 0.6%	154 100.0%
Total	**252** **35.5%**	**52** **7.3%**	**383** **53.9%**	**20** **2.8%**	**3** **0.4%**	**710** **100.0%**

The above table (5.5) describes the marital status of inmates in four districts of Tamilnadu. It shows that 35.5% of inmates (252) remained single in life, 7.3% of inmates (52) got married, 53.9% of inmates (383) widowed, 2.8% of inmates (20) separated and 0.4% of inmates (3) divorced their spouse. All inmates responded to their marital status. In Indian culture, the wife is expected to be younger than her husband. So the highest percentage (53.9%) had fallen on widowed status. It is noteworthy that most inmates were widowed, single or separated. It would be logical to presume that the loneliness in their lives made them seek institutional care facility.

Table 5.6 explains the distribution of inmates by their religion. It reveals that a high proportion of (570) inmates (80.3%) belonged to the Hindu religion. 133

inmates were Christians (18.7%). No male Muslim inmate was found in this study and only 1.0% female Muslim inmates were (7) interviewed. The higher percentage of Hindus in this study could be due to the higher percentage of Hindus in the general population.

Table 5.6 Distribution of inmates by their religion

District	Gender	Hindu		Muslim		Christian		Total
		N	%	N	%	N	%	N
Chennai	Male	38	70.4	0	0.0	16	29.6	54
	Female	145	69.7	1	0.5	62	29.8	208
	Total	183	69.8	1	0.4	78	29.8	**262**
Kanchee -puram	Male	48	92.3	0	0.0	4	7.7	52
	Female	103	95.4	1	0.9	4	3.7	108
	Total	151	94.4	1	0.6	8	5.0	**160**
Vellore	Male	12	75.0	0	0.0	4	25.0	16
	Female	84	71.2	2	1.7	32	27.1	118
	Total	96	71.6	2	1.5	36	26.9	**134**
Thiru -vallur	Male	57	95.0	0	0.0	3	5.0	60
	Female	83	88.3	3	3.2	8	8.5	94
	Total	140	90.9	3	1.9	11	7.1	**154**
Total	Male	155	85.2	0	0.0	27	14.8	182
	Female	415	78.6	7	1.3	106	20.1	528
	Total	**570**	**80.3**	**7**	**1.0**	**133**	**18.7**	**710**

Table 5.7 Distribution of inmates in different types of Old Age Homes

District	Type of Old Age Home			Total
	Free	Paid	Free cum Paid	
Chennai	165 63.0%	67 25.6%	30 11.5%	262 100%
Kanchee puram	49 30.6%	96 60.0%	15 9.4%	160 100%
Vellore	98 73.1%	36 26.9%	0 0.0%	134 100%
Thiru-vallur	68 44.2%	74 48.1%	12 7.8%	154 100%
Total	**380 53.5%**	**273 38.5%**	**57 8.0%**	**710 100%**

Table 5.7 shows the distribution of inmates by the types of old age homes based on their services. Out of 710 inmates, 380 inmates were in free old age homes (53.5%), 273 inmates were in paid homes (38.5%) and only 57 inmates were in free-cum-paid homes (8.0%). On the whole, more than half of the inmates were staying in the free type of old age homes.

Chart 5.4 Distribution of inmates in different types of Old Age Homes

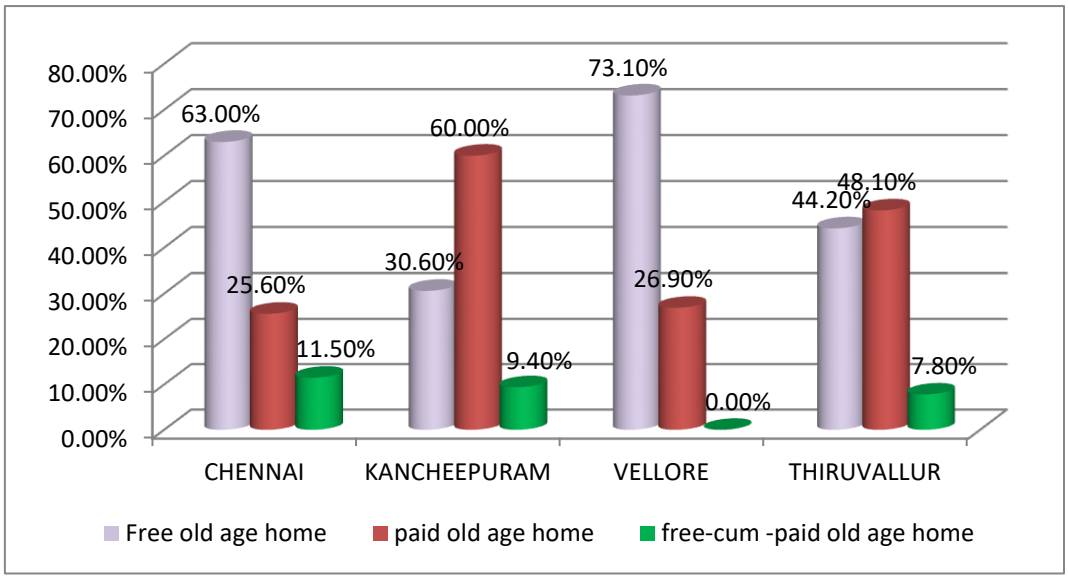


Table 5.8 Distribution of inmates by their Community

Community of inmates	Male		Female		Total	
	N	%	N	%	N	%
FC	36	19.8	112	21.2	148	20.8
BC	63	34.6	129	24.4	192	27.0
MBC	52	28.6	177	33.5	229	32.3
SC	29	15.9	104	19.7	133	18.7
ST	1	0.5	5	0.9	6	0.8
No response	1	0.5	1	0.2	2	0.3
Total	**182**	**100**	**528**	**100**	**710**	**100**

The above table (5.8) shows the distribution of inmates by their community. Majority of inmates (32.3%) belonged to Most Backward Caste, followed by 27% of inmates (192) belonged to Backward Caste, 20.8% of inmates (148) belonged to Forward Caste, 18.7% of inmates (133) belonged to Scheduled Caste, 6 inmates (0.8%) belonged to Scheduled Tribe community and 2 inmates did not respond to this question.

Chart 5.5 Distribution of inmates by their Community

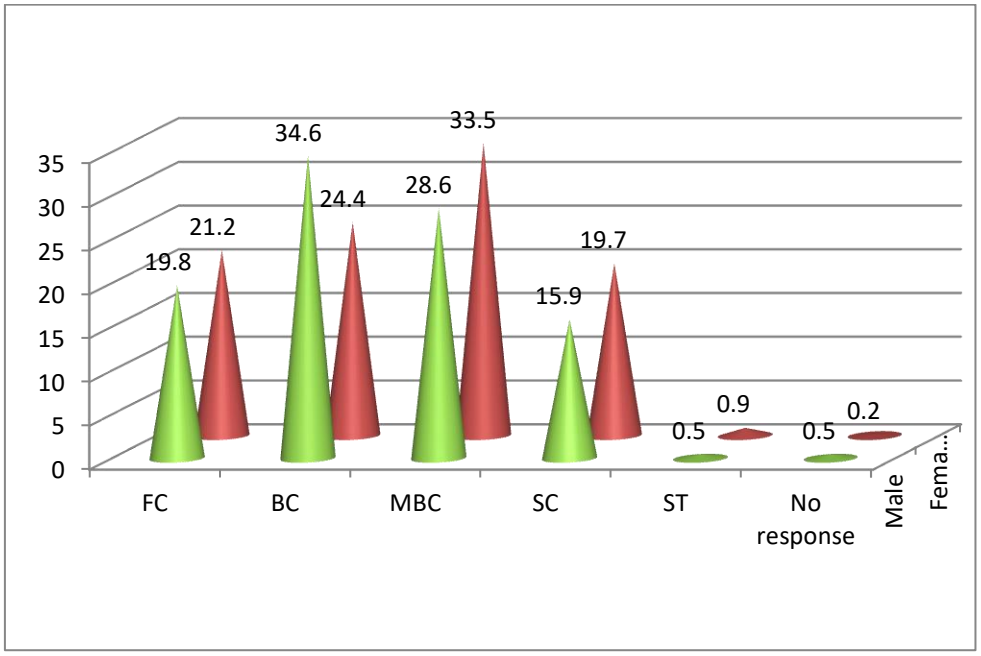


Table 5.9 Number of sons of inmates

Number of sons		Male	Female	Total
One	N	23	47	80
	%	12.6	8.9	11.3
Two	N	18	83	91
	%	9.9	15.7	12.8
Three	N	1	7	8
	%	0.5	1.3	1.1
Above three	N	1	3	4
	%	0.5	0.6	0.6
None	N	73	202	275
	%	40.1	38.2	38.7
Not applicable	N	66	186	252
	%	36.3	35.2	35.5
Total	N	182	528	710
	%	100	100	100

The above table (5.9) reveals the distribution of inmates by their number of sons. 11.3% of inmates (80) had only one son, 12.8% of inmates (91) had two sons, 1.1% of inmates (8) had three sons and only 0.6% of inmates (4) had more than three sons. Out of 710 inmates, 275 inmates (38.7%) had not got a son and 252 inmates (35.5%) were unmarried.

Table 5.10 explains the number of daughters of the inmates. Out of 710 inmates, 35.5% of inmates were single and 41.7% of inmates had not got a daughter. Only 33% of inmates had got daughters, out of them, 14.5% of inmates (103) had got one daughter, 5.8% of inmates (41) got two daughters, 1.4% of inmates (10) got three daughters and 1.1% of inmates (8) had got more than three daughters. Majority of inmates were not willing to stay with their married daughter.

Table 5.10 Number of daughters of inmates

Number of Daughters		Inmates		Total
		Male	Female	
One	N	33	70	103
	%	18.1	13.3	14.5
Two	N	9	32	41
	%	4.9	6.1	5.8
Three	N	5	5	10
	%	2.7	0.9	1.4
Above three	N	0	8	8
	%	0.0	1.5	1.1
None	N	69	227	296
	%	37.9	43.0	41.7
Not applicable	N	66	186	252
	%	36.3	35.2	35.5
Total	**N**	182	528	710
	%	100	100	100

Table 5.11 Number of Grandchildren of inmates

Number of Grandchildren		Male	Female	Total
One	N	26	46	72
	%	14.3	8.7	10.1
Two	N	32	81	113
	%	17.6	15.3	15.9
Three	N	11	59	70
	%	6.0	11.2	9.9
Above three	N	4	12	16
	%	2.2	2.3	2.3
None	N	43	144	158
	%	23.6	27.3	22.2
Not applicable	N	66	186	281
	%	36.3	35.2	39.6
Total	**N**	182	528	710
	%	100	100	100

Table 5.11 reveals the number of grandchildren of the inmates. 10.1% of inmates (72) had got only one grandchild, 15.9% of inmates (113) had two grandchildren, 9.9% of inmates (70) had three grandchildren and 2.3% of inmates (16) had more than three grandchildren. Out of 710 inmates, 158 inmates (22.2%) had not got grandchildren and 281 inmates (39.6%) were not applicable.

Table 5.12 Number of brothers and sisters of inmates

Gender		Number of Brothers and sisters					Total
		Brother	Sister	Both	None	Not applicable	
Male	N	37	46	27	71	1	182
	%	20.3	25.3	14.8	39.0	0.5	100
Female	N	113	99	45	270	1	528
	%	21.4	18.8	8.5	51.1	0.2	100
Total	**N**	**150**	**145**	**72**	**341**	**2**	**710**
	%	**21.1**	**20.4**	**10.1**	**48.0**	**0.3**	**100**

Table 5.12 shows the number of (alive) brothers and sisters of inmates. It is observed that 39% of male inmates and 51.1% of female inmates did not have brothers and sisters. 20.3% of male inmates and 21.4% of female inmates had only brothers. 25.3% of male inmates and 18.8% of female inmates had only sisters. But 10.1% of inmates (72) had both brothers and sisters. Out of 710 inmates, 343 inmates (48.3%) did not have brothers and sisters.

Table 5.13 elaborates the level of education of inmates. The highest percentage falls in the middle school level i.e., 27.6% of inmates (196). They studied up to middle school level. 22.3% of inmates (158) studied up to high school level.

17.9% of inmates (127) studied till primary school level. 17.2% of inmates (122) studied intermediate level and 6.8% of inmates (48) were graduates. 2.4% of inmates (17) had done professional courses and 0.4% of inmates (3) had done other courses. 5.5% of inmates were illiterates (39).

Table 5.13 Education of inmates

Education	District				Total
	Chennai	Kanchee -puram	Vellore	Thiruvallur	
Illiterate	6	6	25	2	39
	2.3%	3.8%	18.7%	1.3%	5.5%
Primary school	52	29	31	15	127
	19.8%	18.1%	23.1%	9.7%	17.9%
Middle school	69	70	41	16	196
	26.3%	43.8%	30.6%	10.4%	27.6%
High school	75	42	14	27	158
	28.6%	26.2%	10.4%	17.5%	22.3%
Intermedi -ate	46	3	12	61	122
	17.6%	1.9%	9.0%	39.6%	17.2%
Graduate	8	8	11	21	48
	3.1%	5.0%	8.2%	13.6%	6.8%
Professio -nal	6	2	0	9	17
	2.3%	1.2%	0.0%	5.8%	2.4%
Others	0	0	0	3	3
	0.0%	0.0%	0.0%	1.9%	0.4%
Total	**262**	**160**	**134**	**154**	**710**
	100.0%	100.0%	100.0%	100.0%	100.0%

Table 5.14 Condition of the spouses of inmates

District		Condition of the spouse							Total
		Passed away	With family	Same institution	With relatives	Another institution	With friends	Not applica ble	
Chennai	N	147	5	12	4	0	0	94	262
	%	56.1	1.9	4.6	1.5	0.0	0.0	35.9	100
Kanchee -puram	N	82	7	0	9	1	1	60	160
	%	51.2	4.4	0.0	5.6	0.6	0.6	37.5	100
Vellore	N	75	6	1	4	0	0	48	134
	%	56.0	4.5	0.7	3.0	0.0	0.0	35.8	100
Thiru -vallur	N	79	8	3	14	0	0	50	154
	%	51.3	5.2	1.9	9.1	0.0	0.0	32.5	100
Total	N	**383**	**26**	**16**	**31**	**1**	**1**	**252**	**710**
	%	**53.9**	**3.7**	**2.3**	**4.4**	**0.1**	**0.1**	**35.5**	**100**

Table 5.14 explains the condition of the spouses of inmates. Out of 710 inmates, 383 inmates' spouse (53.9%) had died, 26 spouses of inmates (3.7%) lived with their family members, 16 spouses (2.3%) of inmates were living in the same old age home, 31 spouses (4.4%) with relatives, 1 spouse (0.1%) was living in another old age home and 1 spouse with his friends. 35.5% of inmates (252) were not applicable to this question, because they were single. On the whole, only 10.6% of inmates' spouses were alive.

Table 5.15 Type of family of inmates

District	Gender	Type of family				Total	
		Nuclear		Extended			
		N	%	N	%	N	%
Chennai	Male	14	25.9	40	74.1	54	100
	Female	66	31.7	142	68.3	208	100
	Total	80	30.5	182	69.5	262	100
Kanchee-puram	Male	16	30.8	36	69.2	52	100
	Female	43	39.8	65	60.2	108	100
	Total	59	36.9	101	63.1	160	100
Vellore	Male	3	18.8	13	81.2	16	100
	Female	26	22.0	92	78.0	118	100
	Total	29	21.6	105	78.4	134	100
Thiruvallur	Male	10	16.7	50	83.3	60	100
	Female	12	12.8	82	87.2	94	100
	Total	22	14.3	132	85.7	154	100
Total	Male	43	23.6	139	76.4	182	100
	Female	147	27.8	381	72.2	528	100
	Total	**190**	**26.8**	**520**	**73.2**	**710**	**100**

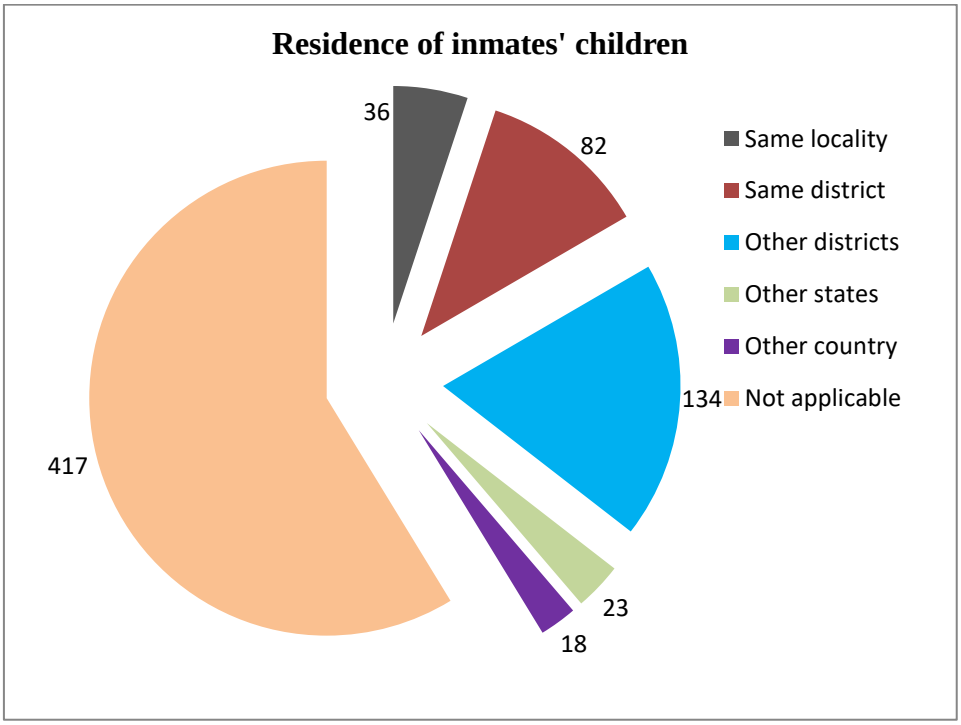
The above table (5.15) reveals the type of family of inmates before they join in old age home. Some inmates were in the nuclear family and others were in a joint family. Majority of inmates (73.2%) lived in an extended family and 26.8% of inmates lived in a nuclear family. Particularly, in Chennai (30.5%) and Kancheepuram (36.9%), more percentage of inmates lived in a nuclear family. But in Vellore (78.4%) and Thiruvallur (85.7%), majority of inmates lived in an extended family.

Table 5.16 Residence of inmates' children

District	Old age home (OAH)	Residence of children						Total N
		Same locality	Same district	Other districts	Other states	Other countries	Not applicable	
Chennai	OAH -1	0.0%	9.5%	47.6%	7.1%	2.4%	33.3%	84
	OAH -2	3.7%	21.0%	18.5%	1.2%	0.0%	55.6%	81
	OAH -3	5.0%	10.0%	10.0%	0.0%	0.0%	75.0%	40
	OAH -4	3.3%	6.7%	6.7%	6.7%	10.0%	66.7%	30
	OAH -5	3.7%	14.8%	7.4%	3.7%	0.0%	70.4%	27
Kanchee puram	OAH -6	4.1%	8.2%	6.1%	2.0%	0.0%	79.6%	49
	OAH -7	13.3%	33.3%	13.3%	0.0%	0.0%	40.0%	15
	OAH -8	10.5%	18.4%	18.4%	0.0%	2.6%	50.0%	38
	OAH -9	9.4%	18.8%	18.8%	6.2%	12.5%	34.4%	32
	OAH -10	3.8%	11.5%	15.4%	7.7%	3.8%	57.7%	26
Vellore	OAH -11	0.0%	7.9%	26.3%	0.0%	0.0%	65.8%	38
	OAH -12	0.0%	0.0%	33.3%	0.0%	0.0%	66.7%	24
	OAH -13	0.0%	0.0%	33.3%	0.0%	0.0%	66.7%	21
	OAH -14	0.0%	0.0%	26.7%	0.0%	0.0%	73.3%	15
	OAH -15	0.0%	5.6%	30.6%	0.0%	0.0%	63.9%	36
Thiru -vallur	OAH -16	12.9%	6.5%	6.5%	3.2%	1.6%	69.4%	62
	OAH -17	0.0%	16.7%	8.3%	16.7%	0.0%	58.3%	12
	OAH -18	0.0%	16.7%	0.0%	0.0%	16.7%	66.7%	6
	OAH -19	12.1%	15.2%	6.1%	6.1%	7.6%	53.0%	66
	OAH -20	12.5%	0.0%	0.0%	0.0%	0.0%	87.5%	8
Total		36 5.1%	82 11.5%	134 18.9%	23 3.2%	18 2.5%	417 58.7%	710 100 %

Table 5.16 shows the residence of inmates' children. 36 inmates' children (5.1%) were residing in the same locality, where the old age home is situated. 82 inmates' children (11.5%) were living in the same district. 134 inmates' children (18.9%) were in other districts of Tamilnadu. 23 inmates' children (3.2%) were in other states of India. Only 2.5% of inmates' children (18) were in abroad. But the majority of inmates (417) in old age home were not applicable to this question. Because many of them were single and others did not have children.

Chart 5.6



5.3 Economic background of inmates

Table 5.17 Past employment status of inmates

District		Employment status							Total
		Not employed	Self-employed	Govt employed	Cooley	Agri culture	Private	No response	
Chennai	N	93	76	12	22	0	59	0	262
	%	35.5	29.0	4.6	8.4	0.0	22.5	0.0	100
Kanchee-puram	N	53	47	11	1	4	44	0	160
	%	33.1	29.4	6.9	0.6	2.5	27.5	0.0	100
Vellore	N	57	35	2	8	11	21	0	134
	%	42.6	26.1	1.5	6.0	8.2	15.7	0.0	100
Thiru-vallur	N	34	30	17	3	6	63	1	154
	%	22.0	19.5	11.0	1.9	3.9	40.9	0.6	100
Total	N	237	188	42	34	21	187	1	710
	%	33.3	26.5	5.9	4.8	3.0	26.3	0.1	100

Table 5.17 explains the past employment status of inmates. Out of 710 inmates, majority (33.3%) of them (237) were not employed and among them, 170 inmates were housewives. 26.5% of them (188) were self-employed, 5.9% of them (42) were government employed, 4.8% of inmates (34) worked as cooley, 3% of inmates (21) worked in the agricultural field, 26.3% of inmates worked in private companies and only one inmate (0.1%) did not respond. **Chart 5.7** follows;

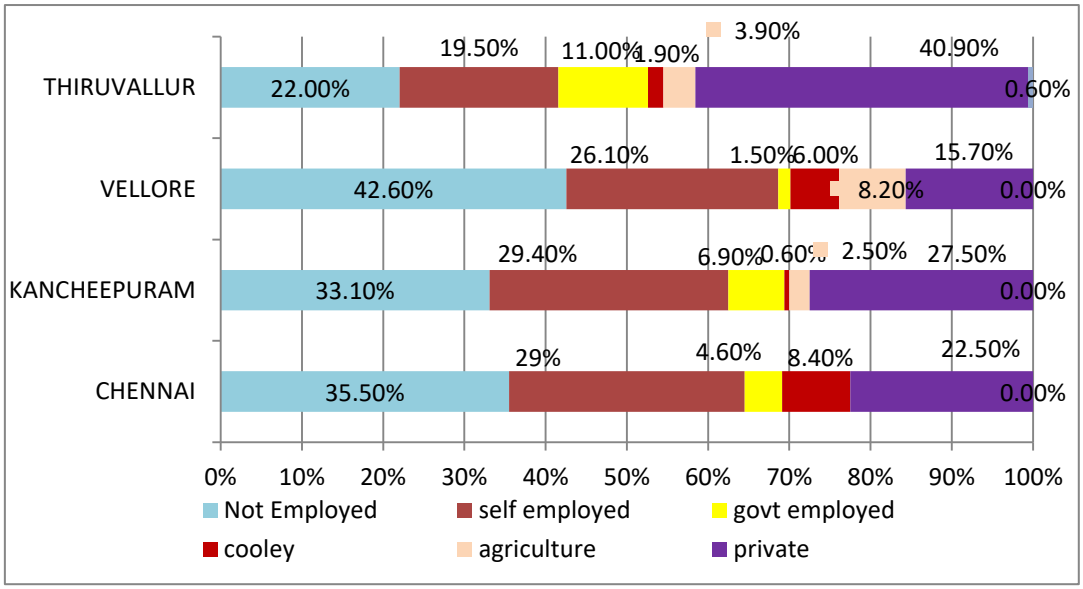


Table 5.18 Monthly earning of inmates in past

Monthly Earning in past (Rs)		District				Total
		Chennai	Kanchee -puram	Vellore	Thiru -vallur	
1-1000	N	43	18	36	6	103
	%	16.4	11.2	26.9	3.9	14.5
1001-3000	N	34	40	28	30	132
	%	13.0	25.0	20.9	19.5	18.6
3001-5000	N	52	37	7	55	151
	%	19.8	23.1	5.2	35.7	21.3
Above 5000	N	40	12	2	28	82
	%	15.3	7.5	1.5	18.2	11.5
None	N	93	53	61	35	242
	%	35.5	33.1	45.5	22.7	34.1
Total	**N**	262	160	134	154	710
	%	100	100	100	100	100

The above table 5.18 reveals the past monthly income of inmates. 34.1% of inmates (242) did not earn any income of their own and were fully dependent on family,

14.5% of inmates (103) earned up to Rs.1000. 18.6% of inmates (132) earned from Rs.1001 to Rs.3000. 21.3% of inmates (151) earned from Rs.3001 to Rs.5000 and 11.5% of inmates (82) earned above Rs.5000 per month. The government employed inmates earned above Rs.5000 and now they receive a pension.

Table 5.19: Distribution of inmates by their pension

Do you receive a pension?	District				Total
	Chennai	Kanchee -puram	Vellore	Thiru -vallur	
Yes	16	13	17	24	70
	6.1%	8.1%	12.7%	15.6%	9.9%
No	246	147	117	130	640
	93.9%	91.9%	87.3%	84.4%	90.1%
Total	262	160	134	154	710
	100%	100%	100%	100%	100%

The above table (5.19) explains the distribution of inmates by the pension they receive. Out of 710 inmates, 90.1% of inmates (640) were not receiving any pension. 9.9 % of inmates (70) were receiving a pension from various schemes i.e., Family pension scheme, Government employee pension scheme and Tamilnadu government old age pension scheme.

Chart 5.8 Distribution of inmates by their pension

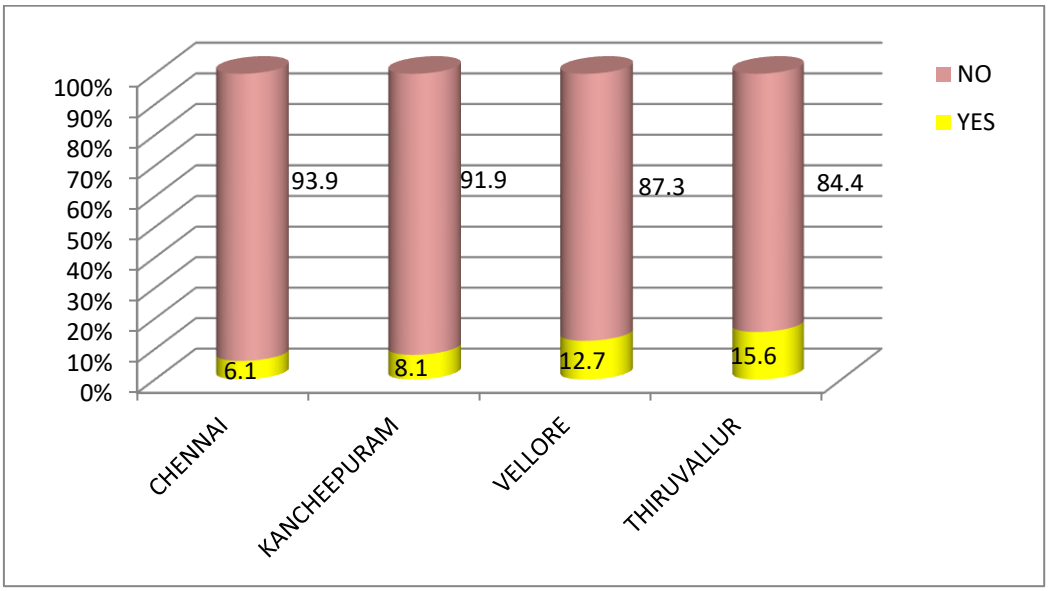


Table 5.20 Amount of pension received by inmates

Amount of pension per month (Rs)	District				Total
	Chennai	Kanchee -puram	Vellore	Thiru -vallur	
1-1000	1 0.4%	3 1.9%	15 11.2%	7 4.5%	26 3.7%
1001-3000	0 0.0%	0 0.0%	0 0.0%	5 3.2%	5 0.7%
3001-5000	9 3.4%	0 0.0%	0 0.0%	0 0.0%	9 1.3%
Above 5000	5 1.9%	11 6.9%	2 1.5%	12 7.8%	30 4.2%
None	247 94.3%	146 91.2%	117 87.3%	130 84.4%	640 90.1%
Total	262 100%	160 100%	134 100%	154 100%	710 100%

The above table (5.20) explains the amount of pension received by the inmates. 90.1% of inmates were not receiving any pension. Only 9.9 % of inmates were receiving a pension from various schemes. Out of them, 3.7% of inmates (26) received the pension below Rs.1001, 0.7% of inmates (5) received pension Rs.1001 to Rs.3000. 1.3% of inmates (9) received Rs.3001 to Rs.5000 and 4.2% of inmates (30) received pension above Rs.5000 per month. Out of 70 inmates, the majority of them were staying in paid homes.

Table 5.21: Distribution of inmates by their pension scheme

Pension scheme	District				Total
	Chennai	Kancheepuram	Vellore	Thiruvallur	
Employee pension	12	11	2	17	42
	4.6%	6.9%	1.5%	11.0%	5.9%
Family pension	2	0	0	0	2
	0.8%	0.0%	0.0%	0.0%	0.3%
TN Government Old age pension	1	3	15	7	26
	0.4%	1.9%	11.2%	4.5%	3.7%
Not applicable	247	146	117	130	640
	94.3%	91.2%	87.3%	84.4%	90.1%
Total	262	160	134	154	710
	100%	100%	100%	100%	100%

Table 5.21 describes the inmates' pension scheme. 5.9% of inmates (42) were receiving a pension under the Government employee pension scheme. Only 0.3% of inmates (2) were receiving the Family pension. 3.7% of inmates (26) were receiving a pension under the Tamilnadu Government old age pension scheme. Majority of inmates (640) were not applicable because they were not receiving any pension.

Chart 5.9 Distribution of inmates by their pension scheme

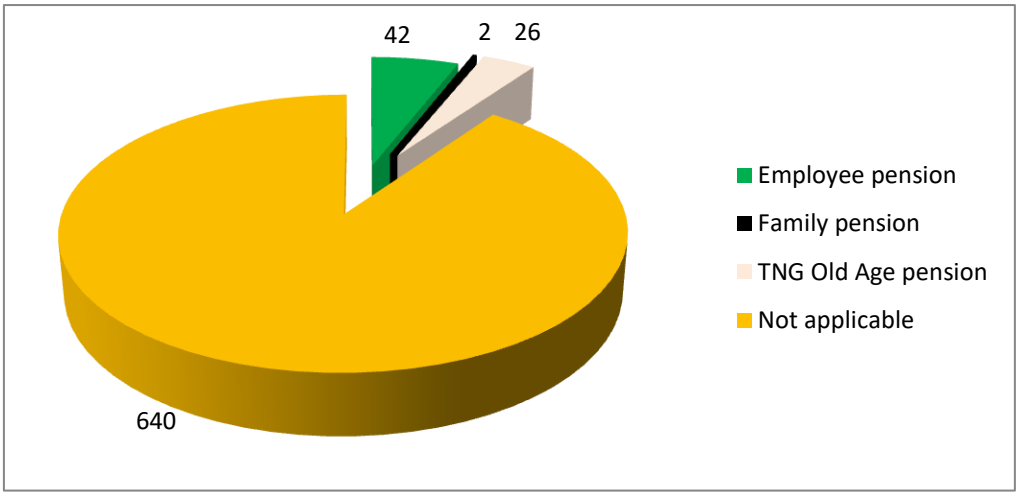


Table 5.22 Reason for spending the retirement money of the inmates

Retirement money spent	District				Total
	Chennai	Kanchee-puram	Vellore	Thiruvallur	
Reinvestment	1	3	0	5	9
	0.4%	1.9%	0.0%	3.2%	1.3%
Child education	1	1	0	2	4
	0.4%	0.6%	0.0%	1.3%	0.6%
Child marriage	4	1	1	0	6
	1.5%	0.6%	0.7%	0.0%	0.8%
Treatment	5	4	1	3	13
	1.9%	2.5%	0.7%	1.9%	1.8%
Housing	2	2	0	7	11
	0.8%	1.2%	0.0%	4.5%	1.5%
Others	1	0	0	0	1
	0.4%	0.0%	0.0%	0.0%	0.1%
Not applicable	248	149	132	137	666
	94.7%	93.1%	98.5%	89.0%	93.8%
Total	262	160	134	154	710
	100.0%	100.0%	100.0%	100.0%	100.0%

Table 5.22 explains how the inmates spent their retirement money. 1.3% of inmates (9) reinvested their money. 0.6% of inmates (4) spent their retirement money for the education of their children and 0.8% of inmates (6) for the marriage of their children. 1.8% of inmates (15) spent for the treatment, 1.5% of inmates (11) spent on house construction and 0.1% of inmates (1) for other purposes. Out of 710 inmates, 666 inmates (93.8%) were not applicable because they did not receive retirement money.

Table 5.23 Sources of income of inmates in old age home

Sources of income	District				Total
	Chennai	Kancheepuram	Vellore	Thiruvallur	
Son	31 11.8%	39 24.4%	20 14.9%	22 14.3%	112 15.8%
Daughter	9 3.4%	20 12.5%	1 0.7%	16 10.4%	46 6.5%
Relatives	31 11.8%	25 15.6%	12 9.0%	18 11.7%	86 12.1%
Pension	15 5.8%	14 8.8%	17 12.7%	24 15.5%	70 9.9%
Property	3 1.1%	5 3.1%	1 0.7%	1 0.6%	10 1.4%
None	173 66.0%	57 35.6%	83 61.9%	73 47.4%	386 54.4%
Total	262 100.0%	160 100.0%	134 100.0%	154 100.0%	710 100.0%

The above table (5.23) illustrates the distribution of inmates by their present sources of income. Out of 710 inmates, 54.4% of them (386) did not receive any income and they stayed in free homes. 1.4% of them received income from their property, 9.9% of them from a pension, 12.1% of them from relatives, 6.5% of them from daughters and 15.8% of inmates' source of income were their sons.

Table 5.24 explains the detail of assets owned by inmates before they join in the old age home. Out of 710 inmates, only 10 inmates (1.4%) still maintain their own assets. 3 inmates (0.4%) had land assets. 5 inmates (0.7%) had their own house and 2 inmates (0.3%) maintained their business and were receiving income. These inmates had stayed in paid homes and economically independent by their assets.

Table 5.24 Distribution of inmates by their assets

District	Assets owned by inmates				Total
	Land	House	Business	None	
Chennai	0	1	2	259	262
	0.0%	0.4%	0.8%	98.9%	100%
Kancheepuram	3	2	0	155	160
	1.9%	1.2%	0.0%	96.9%	100%
Vellore	0	1	0	133	134
	0.0%	0.7%	0.0%	99.3%	100%
Thiruvallur	0	1	0	153	154
	0.0%	0.6%	0.0%	99.4%	100%
Total	3	5	2	700	710
	0.4%	0.7%	0.3%	98.6%	100%

Table 5.25 Distribution of Inmates by their saving behaviour

District	Do you have savings?		Total
	Yes	No	
Chennai	70	192	262
	26.7%	73.3%	100.0%
Kancheepuram	33	127	160
	20.6%	79.4%	100.0%
Vellore	24	110	134
	17.9%	82.1%	100.0%
Thiruvallur	74	80	154
	48.1%	51.9%	100.0%
Total	201	509	710
	28.3%	71.7%	100.0%

The above table (5.25) elaborates the savings of inmates. The sources of income of inmates were very less and the majority of inmates (424) did not have any sources of income and they cannot save any money. Those who were receiving a pension or receiving money from son or daughter or relatives can save their money. Out of 710 inmates, 201 inmates (28.3%) had some savings. 509 inmates (71.7%) did not have any savings.

Table 5.26 Distribution of Inmates by their type of room in old age homes

District	Old age home (OAH)	Type of room				Total Inmates N
		Dormitory	Single occupied	Twin sharing	Triple sharing	
Chennai	OAH -1	100.0%	0.0%	0.0%	0.0%	84
	OAH -2	22.2%	1.2%	58.0%	18.5%	81
	OAH -3	0.0%	70.0%	30.0%	0.0%	40
	OAH -4	60.0%	0.0%	23.3%	16.7%	30
	OAH -5	0.0%	0.0%	51.9%	48.1%	27
Kanche epuram	OAH -6	100.0%	0.0%	0.0%	0.0%	49
	OAH -7	0.0%	0.0%	60.0%	40.0%	15
	OAH -8	0.0%	0.0%	68.4%	31.6%	38
	OAH -9	100.0%	0.0%	0.0%	0.0%	32
	OAH -10	0.0%	0.0%	65.4%	34.6%	26
Vellore	OAH -11	100.0%	0.0%	0.0%	0.0%	38
	OAH -12	62.5%	0.0%	0.0%	37.5%	24
	OAH -13	0.0%	0.0%	100.0%	0.0%	21
	OAH -14	100.0%	0.0%	0.0%	0.0%	15
	OAH -15	0.0%	0.0%	100.0%	0.0%	36
Thiru -vallur	OAH -16	100.0%	0.0%	0.0%	0.0%	62
	OAH -17	100.0%	0.0%	0.0%	0.0%	12
	OAH -18	0.0%	0.0%	0.0%	100.0%	6
	OAH -19	0.0%	0.0%	100.0%	0.0%	66
	OAH -20	0.0%	100.0%	0.0%	0.0%	8
Total		343	37	255	75	710
		48.3%	5.2%	35.9%	10.6%	100.0%

Table 5.26 reveals the type of rooms in old age homes. Nearly half (48.3%) of the inmates (343) were staying in dormitories. Many old age homes had twin sharing rooms and triple sharing rooms. Out of 710 inmates, 35.9% of inmates (255) were staying in twin sharing rooms, 10.6% of inmates (75) were in triple sharing rooms and 37 inmates (5.2%) were staying alone in a single occupied room. Majority of single occupied rooms were attached with a restroom facility.

Chart 5.10 Distribution of inmates by their types of room

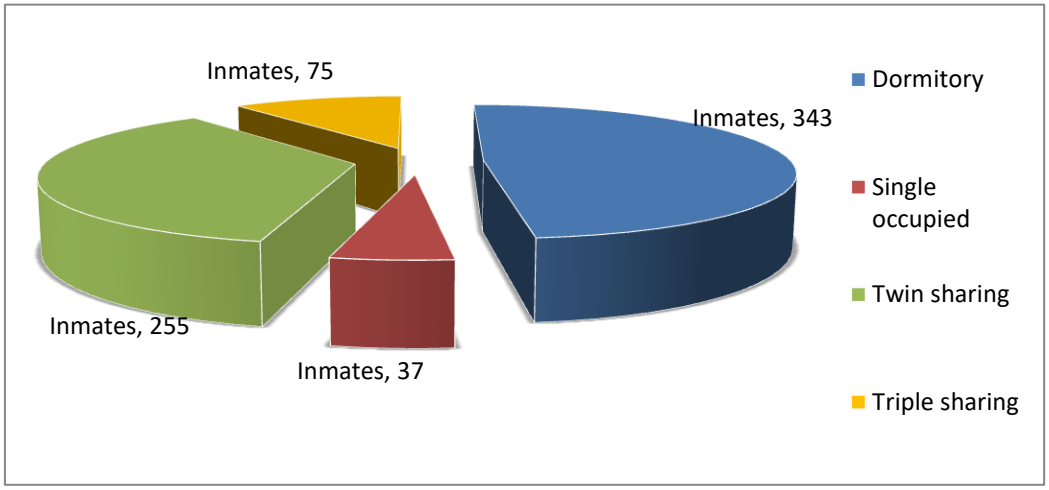


Table 5.27 Number of roommates in old age home

District	Number of roommates			Total
	1-3	4-6	Above 6	
Chennai	143	63	56	262
	54.6%	24.0%	21.4%	100.0%
Kancheepuram	76	84	0	160
	47.5%	52.5%	0.0%	100.0%
Vellore	66	30	38	134
	49.3%	22.4%	28.4%	100.0%
Thiruvallur	82	72	0	154
	53.2%	46.8%	0.0%	100.0%
Total	367	249	94	710
	51.7%	35.1%	13.2%	100.0%

The above table (5.27) explains the number of roommates stayed in one room. 51.7% of inmates (367) had stayed with 1 - 3 roommates. 35.1% of inmates (249) had stayed with 4 - 6 roommates and 13.2% of inmates (94) stayed with above six roommates. In paid homes, people who pay more get more facilities and privacy in their rooms.

Table 5.28 explains the reasons to join in old age homes. Inmates joined in an old age home for different reasons. 38.5% of inmates (273) stated that they did not have anybody to take care of them. 42.1 % of inmates (299) had problems with their family members. 11% of inmates (78) faced the financial problem and that made them to join the old age home. Out of 710 inmates, 60 of them (8.5%) wanted to live independently.

Table 5.28 Reasons to join in old age home

District	Old age home (OAH)	Reasons to join in old age home				Total Inmates N
		Nobody to take care	Family problem	Financial problem	Want to Live independently	
Chennai	OAH -1	21.4%	58.3%	0.0%	20.2%	84
	OAH -2	67.9%	24.7%	7.4%	0.0%	81
	OAH -3	17.5%	52.5%	5.0%	25.0%	40
	OAH -4	23.3%	33.3%	33.3%	10.0%	30
	OAH -5	22.2%	37.0%	25.9%	14.8%	27
Kanchee -puram	OAH -6	24.5%	44.9%	24.5%	6.1%	49
	OAH -7	46.7%	33.3%	20.0%	0.0%	15
	OAH -8	15.8%	71.1%	13.2%	0.0%	38
	OAH -9	15.6%	65.6%	18.8%	0.0%	32
	OAH -10	19.2%	61.5%	19.2%	0.0%	26
Vellore	OAH -11	47.4%	34.2%	18.4%	0.0%	38
	OAH -12	50.0%	33.3%	16.7%	0.0%	24
	OAH -13	57.1%	28.6%	14.3%	0.0%	21
	OAH -14	40.0%	40.0%	20.0%	0.0%	15
	OAH -15	47.2%	30.6%	13.9%	8.3%	36
Thiruval lur	OAH -16	77.4%	22.6%	0.0%	0.0%	62
	OAH -17	75.0%	25.0%	0.0%	0.0%	12
	OAH -18	83.3%	16.7%	0.0%	0.0%	6
	OAH -19	24.2%	51.5%	0.0%	24.2%	66
	OAH -20	25.0%	25.0%	0.0%	50.0%	8
Total		**273**	**299**	**78**	**60**	**710**
		38.5%	**42.1%**	**11.0%**	**8.5%**	**100.0%**

Chart 5.11 Reasons to join in old age home

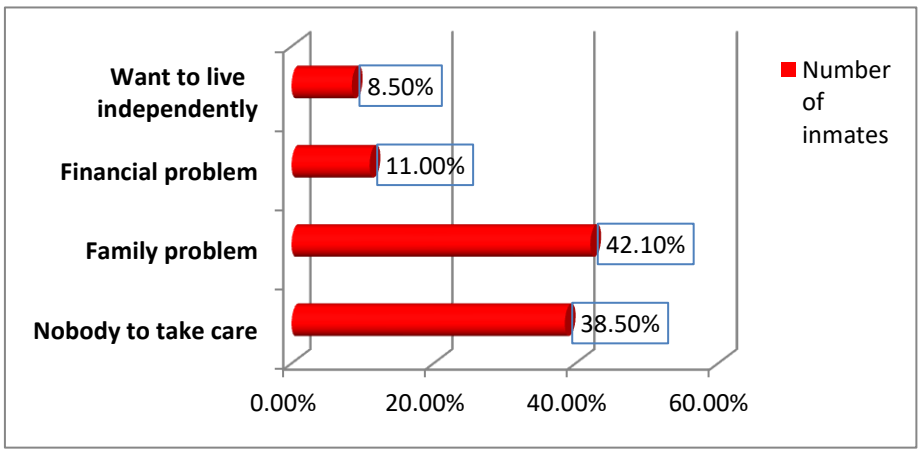


Table 5.29 Duration of stay of inmates in old age home

Age	Duration of stay of inmates in old age home				Total
	< 1 year	1-5 years	5-10 years	> 10 years	
60-69	58	60	7	2	127
	45.7%	47.2%	5.5%	1.6%	100.0%
70-79	61	170	72	4	307
	19.9%	55.4%	23.5%	1.3%	100.0%
80-89	17	107	95	25	244
	7.0%	43.9%	38.9%	10.2%	100.0%
90-99	1	10	12	9	32
	3.1%	31.2%	37.5%	28.1%	100.0%
Total	137	347	186	40	710
	19.3%	48.9%	26.2%	5.6%	100.0%

This table (5.29) reveals that there is a correlation between the duration of stay of inmates and the age group of inmates. 19.3% of inmates (137) had stayed for less than one year. 48.9% of inmates (347) had stayed one year to less than five year. 26.2% of inmates (186) had stayed five years to ten years and 5.6% of inmates had stayed above ten years in the old age home. The longest duration of inmates' stay was 15 years in this research work.

Table 5.30 Inmates' plan to stay with their family members

Age	Plan to stay with family		Total
	Yes	No	
Chennai	20	242	262
	7.6%	92.4%	100.0%
Kancheepuram	29	131	160
	18.1%	81.9%	100.0%
Vellore	13	121	134
	9.7%	90.3%	100.0%
Thiruvallur	23	131	154
	14.9%	85.1%	100.0%
Total	85	625	710
	12.0%	88.0%	100.0%

The above table explains the interest of inmates to stay with their family members. Out of 710 inmates, only 85 inmates (12%) were willing to go back to their home and stay with their family members. 88% of inmates (624) were not willing to

stay with their family members and they stated that they don't want to be a burden to them and they are happy, interactive and comfortable in the old age homes.

Table 5.31 Distribution of inmates by their plan to move from old age home

Age	Plan to move from OAH		Total
	Yes	No	
Chennai	29	233	262
	11.1%	88.9%	100.0%
Kancheepuram	21	139	160
	13.1%	86.9%	100.0%
Vellore	14	120	134
	10.4%	89.6%	100.0%
Thiruvallur	26	128	154
	16.9%	83.1%	100.0%
Total	90	620	710
	12.7%	87.3%	100.0%

Table 5.31 shows the distribution of inmates by their future plan of moving from old age home. Some inmates who stayed in paid homes wanted to move from their old age home to another home. Only 12.7% of inmates (90) were willing to move from old age home. But, majority of inmates (620) had not got the plan to move from their old age home.

Table 5.32 Psychological problems of inmates

Age	Psychological problem				Total
	Depression	Loneliness	Helplessness	None	
60-69	30	6	29	62	127
	23.6%	4.7%	22.8%	48.8%	100.0%
70-79	82	9	59	157	307
	26.7%	2.9%	19.2%	51.1%	100.0%
80-89	56	2	43	143	244
	23.0%	0.8%	17.6%	58.6%	100.0%
90-99	5	0	2	25	32
	15.6%	0.0%	6.2%	78.1%	100.0%
Total	173	17	133	387	710
	24.4%	2.4%	18.7%	54.5%	100.0%

The above table (5.32) reveals that majority of inmates (54.5%) did not have any psychological problems. Nearly one fourth of inmates (24.4%) had depression.

CHAPTER VI

Evaluation of Life satisfaction of inmates

Life satisfaction measures global cognitive judgement with one's quality of life (Diener, 1985) and is one of the factors that determine subjective well-being (Diener, 1984). It is one of the aspects that determine successful ageing, and thus the quality of life. Life satisfaction measures have been widely used in the last decades (Diener, 2015) and its level changes over the life span according to a U-shaped curve. This construct is considered to be an important predictor for psychological well-being.

Life satisfaction is an overall assessment of feelings and attitudes about one's life at a particular point in time ranging from negative to positive. It is one of three major indicators of well-being: life satisfaction, positive affect, and negative affect (Diener, 1984). Studies have found that life satisfaction among older adults is influenced by many different factors like demographic factors, income, physical health, and housing conditions (Oswald, 2012). The premises of life satisfaction in light of the specific conditions of later life have been explored within various theoretical approaches. Firstly, life satisfaction is sometimes considered as a component of a broad construct, such as successful ageing. Secondly, the association between perceived personal control and life satisfaction represents a field of great interest within gerontology. Finally, the social network is an important part of life circumstances in late life.

To analyse the life satisfaction of inmates' two research tools have been used. They are 1) Satisfaction with life scale (SWLS) and 2) Oxford Happiness Questionnaire (OHQ).

6.1 Research tool 1: Satisfaction with life scale (SWLS)

This scale consists of five statements with seven point scale. The highest score '7' is given to 'strongly agree' and the lowest score '1' is given to 'strongly disagree'. Table 6.1.1 shows the distribution of inmates by their idea about statement -1 'In most ways my life is close to my ideal'. 13.4% of inmates (95) strongly disagree with the statement, 28.2% of inmates (200) disagree with the statement, 32.8% of inmates (233) slightly disagree, 20.3% of inmates neither agree nor disagree, 3.5% of

inmates (25) slightly agree and 1.8% of inmates (13) agree with the statement. But no one strongly agrees (0.0%) with the statement -1.

Table 6.1.1 - Statement 1

1) In most ways, my life is close to my ideal		Gender		Total
		Male	Female	
Strongly agree	N	0	0	0
	%	0.0	0.0	0.0
Agree	N	3	10	13
	%	1.6	1.9	1.8
Slightly agree	N	8	17	25
	%	4.4	3.2	3.5
Neither agree nor disagree	N	35	109	144
	%	19.2	20.6	20.3
Slightly disagree	N	48	185	233
	%	26.4	35.0	32.8
Disagree	N	58	142	200
	%	31.9	26.9	28.2
Strongly disagree	N	30	65	95
	%	16.5	12.3	13.4
Total	N	182	528	710
	%	100.0	100.0	100.0

Table 6.1.2 - Statement 2

2) The conditions of my life are excellent		Gender		Total
		Male	Female	
Strongly agree	N	0	0	0
	%	0.0	0.0	0.0
Agree	N	11	25	36
	%	6.0	4.7	5.1
Slightly agree	N	12	21	33
	%	6.6	4.0	4.6
Neither agree nor disagree	N	18	57	75
	%	9.9	10.8	10.6
Slightly disagree	N	36	144	180
	%	19.8	27.3	25.4
Disagree	N	63	150	213
	%	34.6	28.4	30.0
Strongly disagree	N	42	131	173
	%	23.1	24.8	24.4
Total	N	182	528	710
	%	100.0	100.0	100.0

The above table (6.1.2) shows the distribution of inmates by their idea about statement -2 ‘The conditions of my life are excellent’. 24.4% of inmates (173) strongly disagree with the statement, 30.0% of inmates (213) disagree with the statement, 25.4% of inmates (180) slightly disagree, 10.6% of inmates (75) neither agree nor disagree, 4.6% of inmates (33) slightly agree and 5.1% of inmates (36) agree with the statement. But no one strongly agrees (0.0%) with the statement -2.

Table 6.1.3 - Statement 3

3) I am satisfied with my life		**Gender**		**Total**
		Male	**Female**	
Strongly agree	N	0	0	0
	%	0.0	0.0	0.0
Agree	N	24	73	97
	%	13.2	13.8	13.7
Slightly agree	N	25	108	133
	%	13.7	20.5	18.7
Neither agree nor disagree	N	28	69	97
	%	15.4	13.1	13.7
Slightly disagree	N	47	120	167
	%	25.8	22.7	23.5
Disagree	N	49	119	168
	%	26.9	22.5	23.7
Strongly disagree	N	9	39	48
	%	4.9	7.4	6.8
Total	N	182	528	710
	%	100	100	100.0

The above table (6.1.3) shows the distribution of inmates and their idea about statement - 3 ‘I am satisfied with my life’. 6.8% of inmates (48) strongly disagree with the statement, 23.7% of inmates (168) disagree with the statement, 23.5% of inmates (167) slightly disagree, 13.7% of inmates (97) neither agree nor disagree, 18.7% of inmates (133) slightly agree and 13.7% of inmates (97) agree with the statement. But no one strongly agrees (0.0%) with the statement -3.

Table 6.1.4 shows the distribution of inmates by their idea about the statement - 4 ‘So far I have gotten the important things I want in life’. 2.7% of inmates (19) strongly disagree with the statement, 11.5% of inmates (82) disagree with the statement, 25.6% of inmates (182) slightly disagree, 9.2% of inmates (65) neither agree

nor disagree, 31.8% of inmates (226) slightly agree, 18.0% of inmates (128) agree with the statement and 1.1% of inmates strongly agree (8) with the statement -4.

Table 6.1.4 - Statement 4

4) So far I have gotten the important things I want in life		Gender		Total
		Male	Female	
Strongly agree	N	2	6	8
	%	1.1	1.1	1.1
Agree	N	29	99	128
	%	15.9	18.8	18.0
Slightly agree	N	54	172	226
	%	29.7	32.6	31.8
Neither agree nor disagree	N	22	43	65
	%	12.1	8.1	9.2
Slightly disagree	N	50	132	182
	%	27.5	25.0	25.6
Disagree	N	21	61	82
	%	11.5	11.6	11.5
Strongly disagree	N	4	15	19
	%	2.2	2.8	2.7
Total	N	182	528	710
	%	100.0	100.0	100.0

Table 6.1.5 - Statement 5

5) If I could live my life over, I would change almost nothing		Gender		Total
		Male	Female	
Strongly agree	N	16	57	73
	%	8.8	10.8	10.3
Agree	N	77	218	295
	%	42.3	41.3	41.5
Slightly agree	N	53	166	219
	%	29.1	31.4	30.8
Neither agree nor disagree	N	36	87	123
	%	19.8	16.5	17.3
Slightly disagree	N	0	0	0
	%	0.0	0.0	0.0
Disagree	N	0	0	0
	%	0.0	0.0	0.0
Strongly disagree	N	0	0	0
	%	0.0	0.0	0.0
Total	N	182	528	710
	%	100.0	100.0	100.0

Table 6.1.5 shows the distribution of inmates by their idea about statement -5 'If I could live my life over, I would change almost nothing'.17.3% of inmates (123) neither agree nor disagree with this statement, 30.8% of inmates (219) slightly agree, 41.5% of inmates (295) agree and 10.3% of inmates strongly agree. But no one in the home disagree (strongly disagree (0.0%), disagree (0.0%) and slightly disagree (0.0%)) with the statement -5.

6.2 Research tool 2: Oxford Happiness Questionnaire

Table 6.2.1 – Statements 1 to 3

Statements		The Oxford Happiness Questionnaire						Total
		Strongly disagree	Moderately Disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree	
1.I don't feel particularly pleased with the way I am	N	0	124	166	148	185	87	710
	%	0.0	17.5	23.4	20.8	26.1	12.3	100
2. I am intensely interested in other people.	N	18	144	142	126	210	70	710
	%	2.5	20.3	20.0	17.7	29.6	9.9	100
3.I feel that life is very rewarding	N	48	167	245	189	40	21	710
	%	6.8	23.5	34.5	26.6	5.6	3.0	100

The above table (6.2.1) reveals the distribution of inmates by their idea about the statements of the oxford happiness questionnaire.

Statement -1: 'I don't feel particularly pleased with the way I am'. This statement was moderately agreed by the majority of (185) inmates (26.1%). but no one in the home strongly disagreed (0.0%) with this statement.

Statement -2: 'I am intensely interested in other people'. This statement was moderately agreed by (29.6%) majority of (210) inmates and strongly disagreed by 2.5% of inmates (18).

Statement -3: 'I feel that life is very rewarding'. This statement was slightly disagreed by the majority of (245) inmates (34.5%) and strongly agreed by 3.0% of inmates (21).

Table 6.2.2 – Statements 4 to 6

Statements		The Oxford Happiness Questionnaire						Total
		Strongly disagree	Moderately Disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree	
4.I have very warm feelings towards almost everyone	N	36	134	63	129	248	100	710
	%	5.1	18.9	8.9	18.2	34.9	14.1	100
5.I rarely wake up feeling rested	N	0	7	162	262	213	66	710
	%	0.0	1.0	22.8	36.9	30.0	9.3	100
6.I am not particularly optimistic about the future	N	8	74	258	208	130	32	710
	%	1.1	10.4	36.3	29.3	18.3	4.5	100

The above table (6.2.2) reveals the distribution of inmates by their idea about the statements of the oxford happiness questionnaire.

Statement -4: 'I have very warm feelings towards almost everyone'. This statement was moderately agreed by the majority (34.9%) of inmates (248) and strongly disagreed by 5.1% of inmates (36).

Statement -5: 'I rarely wake up feeling rested'. This statement was slightly agreed by (36.9%) majority of inmates (262) and moderately disagreed by only 1.0% of inmates (7).

Statement -6: 'I am not particularly optimistic about the future'. This statement was slightly disagreed by (36.3%) majority of inmates (258) and strongly disagreed by only 1.1% of inmates (8).

Table 6.2.3 reveals the distribution of inmates by their idea about the statements of the oxford happiness questionnaire.

Statement -7: 'I find most things amusing'. This statement was slightly disagreed by (47.6%) majority of inmates (338) and no one strongly agreed (0.0%) with this statement.

Statement -8: 'I am always committed and involved'. This statement was slightly disagreed by (38.3%) majority of inmates (272) and strongly agreed by only 1.1% of inmates (8).

Statement -9: 'life is good'. This statement was slightly disagreed by (38.7%) majority of inmates (275) and no one strongly disagreed (0.0%) with this statement.

Table 6.2.3 – Statements 7 to 9

Statements		The Oxford Happiness Questionnaire						Total
		Strongly disagree	Moderately Disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree	
7.I find most things amusing	N	33	203	338	120	16	0	710
	%	4.6	28.6	47.6	16.9	2.3	0.0	100
8. I am always committed and involved	N	92	186	272	123	29	8	710
	%	13.0	26.2	38.3	17.3	4.1	1.1	100
9. life is good	N	0	154	275	122	119	40	710
	%	0.0	21.7	38.7	17.2	16.8	5.6	100

Table 6.2.4 – Statements 10 to 12

Statements		The Oxford Happiness Questionnaire						Total
		Strongly disagree	Moderately Disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree	
10.I do not think that the world is a good place	N	0	112	287	269	42	0	710
	%	0.0	15.8	40.4	37.9	5.9	0.0	100
11.I laugh a lot	N	64	194	320	110	14	8	710
	%	9.0	27.3	45.1	15.5	2.0	1.1	100
12.I am well satisfied with everything in my life	N	75	286	278	71	0	0	710
	%	10.6	40.3	39.2	10.0	0.0	0.0	100

The above table (6.2.4) reveals the distribution of inmates by their idea about the statements of the oxford happiness questionnaire.

Statement -10: 'I do not think that the world is a good place'. This statement was slightly disagreed by (40.4%) majority of inmates (287) and no one strongly agreed and strongly disagreed (0.0%) with this statement.

Statement -11: 'I laugh a lot'. This statement was slightly disagreed by (45.1%) majority of inmates (320) and strongly agreed by only 1.1% of inmates (8).

Statement -12: 'I am well satisfied with everything in my life'. This statement was moderately disagreed by (40.3%) majority of inmates (286) and no one moderately agreed and strongly agreed (0.0%) with this statement.

Table 6.2.5 – Statement 13 to 15

Statements		The Oxford Happiness Questionnaire						Total
		Strongly disagree	Moderately Disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree	
13.I don't think I look attractive	N	0	11	61	278	308	52	710
	%	0.0	1.5	8.6	39.2	43.4	7.3	100
14.There is a gap between what I would like to do and what I have done	N	0	0	121	301	239	49	710
	%	0.0	0.0	17.0	42.4	33.7	6.9	100
15. I am very happy	N	0	281	252	132	45	0	710
	%	0.0	39.6	35.5	18.6	6.3	0.0	100

The above table (6.2.5) reveals the distribution of inmates by their idea about the statements of the oxford happiness questionnaire.

Statement -13: 'I don't think I look attractive'. This statement was moderately agreed by (43.4%) majority of inmates (308) and no one strongly disagreed (0.0%) with this statement.

Statement -14: 'There is a gap between what I would like to do and what I have done'. This statement was slightly agreed by (42.4%) majority of inmates (301) and no one strongly disagreed and moderately disagreed (0.0%) with this statement.

Statement -15: ‘I am very happy’. This statement was moderately disagreed by (39.6%) majority of inmates (281) and no one strongly disagreed and strongly agreed (0.0%) with this statement.

Table 6.2.6 – Statements 16 to 18

Statements		The Oxford Happiness Questionnaire						Total
		Strongly disagree	Moderately Disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree	
16. I find beauty in some things	N	15	186	306	150	53	0	710
	%	2.1	26.2	43.1	21.1	7.5	0.0	100
17. I always have a cheerful effect on others	N	43	199	269	157	42	0	710
	%	6.1	28.0	37.9	22.1	5.9	0.0	100
18. I can fit in (find time for) everything I want to.	N	24	217	278	148	43	0	710
	%	3.4	30.6	39.2	20.8	6.1	0.0	100

The above table (6.2.6) reveals the distribution of inmates by their idea about the statements of the oxford happiness questionnaire.

Statement -16: ‘I find beauty in some things’. This statement was slightly disagreed by (43.1%) majority of inmates (306) and no one strongly agreed (0.0%) with this statement.

Statement -17: ‘I always have a cheerful effect on others’. This statement was slightly disagreed by (37.9%) majority of inmates (269) and no one strongly agreed (0.0%) with this statement

Statement -18: ‘I can fit in (find time for) everything I want to’. This statement was slightly disagreed by (39.2%) majority of inmates (278) and no one strongly agreed (0.0%) with this statement.

Table (6.2.7) reveals the distribution of inmates by their idea about the statements of the oxford happiness questionnaire. Statement -19: ‘I feel that I am not especially in control of my life’. This statement was moderately agreed by (33.4%) majority of inmates (237) and no one strongly disagreed (0.0%) with this statement.

Statement -20: ‘I feel able to take anything on’. This statement was slightly disagreed by (39.3%) majority of inmates (279) and no one strongly disagreed and strongly agreed (0.0%) with this statement

Statement -21: ‘I feel fully mentally alert’. This statement was slightly disagreed by (34.6%) majority of inmates (246) and no one strongly agreed (0.0%) with this statement.

Table 6.2.7 – Statements 19 to 21

Statements		The Oxford Happiness Questionnaire						Total
		Strongly disagree	Moderately Disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree	
19. I feel that I am not especially in control of my life.	N	0	64	135	161	237	113	710
	%	0.0	9.0	19.0	22.7	33.4	15.9	100
20. I feel able to take anything on.	N	0	104	279	214	113	0	710
	%	0.0	14.6	39.3	30.1	15.9	0.0	100
21. I feel fully mentally alert	N	72	167	246	183	42	0	710
	%	10.1	23.5	34.6	25.8	5.9	0.0	100

Table 6.2.8 reveals the distribution of inmates by their idea about the statements of the oxford happiness questionnaire.

Statement -22: ‘I often experience joy and elation’. This statement was slightly disagreed by (29.7%) majority of inmates (211) and no one strongly agreed (0.0%) with this statement.

Statement -23: ‘I don’t find it easy to make decisions’. This statement was moderately agreed by (47.0%) majority of inmates (334) and no one strongly disagreed (0.0%) with this statement

Statement -24: ‘I don’t have a particular sense of meaning and purpose in my life’. This statement was slightly disagreed by (33.1%) majority of inmates (235) and no one strongly agreed (0.0%) with this statement.

Table 6.2.8 – Statements 22 to 24

Statements		The Oxford Happiness Questionnaire						Total
		Strongly disagree	Moderately Disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree	
22.I often experience joy and elation	N	124	140	211	161	74	0	710
	%	17.5	19.7	29.7	22.7	10.4	0.0	100
23.I don't find it easy to make decisions	N	0	53	95	176	334	52	710
	%	0.0	7.5	13.4	24.8	47.0	7.3	100
24.I don't have a particular sense of meaning and purpose in my life	N	0	11	90	235	166	208	710
	%	0.0	1.5	12.7	33.1	23.4	29.3	100

Table 6.2.9 – Statements 25 and 26

Statements		The Oxford Happiness Questionnaire						Total
		Strongly disagree	Moderately Disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree	
25.I feel I have a great deal of energy	N	109	294	214	77	16	0	710
	%	15.4	41.4	30.1	10.8	2.3	0.0	100
26. I usually have a good influence on events.	N	42	247	285	116	20	0	710
	%	5.9	34.8	40.1	16.3	2.8	0.0	100

The above table (6.2.9) reveals the distribution of inmates by their idea about the statements of the oxford happiness questionnaire.

Statement -25: 'I feel I have a great deal of energy'. This statement was moderately disagreed by (41.4%) majority of inmates (294) and no one strongly agreed (0.0%) with this statement.

Statement -26: ‘I usually have a good influence on events’. This statement was slightly disagreed by (40.1%) majority of inmates (285) and no one strongly agreed (0.0%) with this statement.

Table 6.2.10 – Statements 27 to 29

Statements		The Oxford Happiness Questionnaire						Total
		Strongly disagree	Moderately Disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree	
27. I don’t have fun with other people.	N	0	0	153	279	236	42	710
	%	0.0	0.0	21.5	39.3	33.2	5.9	100
28. I don’t feel particularly healthy.	N	64	75	176	216	108	71	710
	%	9.0	10.6	24.8	30.4	15.2	10.0	100
29. I don’t have particularly happy memories of the past.	N	99	282	262	67	0	0	710
	%	13.9	39.7	36.9	9.4	0.0	0.0	100

The above table (6.2.10) reveals the distribution of inmates by their idea about the statements of the oxford happiness questionnaire.

Statement -27: ‘I don’t have fun with other people’. This statement was slightly agreed by (39.3%) majority of inmates (279) and no one strongly disagreed and moderately disagreed (0.0%) with this statement.

Statement -28: ‘I don’t feel particularly healthy’. This statement was slightly agreed by (30.4%) majority of inmates (216) and strongly disagreed by 9% of inmates (64).

Statement -29: ‘I don’t have particularly happy memories of the past’. This statement was moderately disagreed by (39.7%) majority of inmates (282) and no one moderately agreed and strongly agreed (0.0%) with this statement.

Table 6.3 shows that majority of inmates (408) in old age home (57.5%) moderately had negative feelings. 21.5% of inmates completely had negative feelings and 21.0% of inmates did not have negative feelings. Majority of inmates (57.5%) were

moderately satisfied with themselves. 33.1% of inmates was not at all satisfied but 9.4% of inmates were completely satisfied by themselves.

Table 6.3 Inmates' level of negative feelings and their satisfaction

Quality of life of inmates			Not at all	Moderately	Completely	Total
1. How often do you have negative feelings?	Male	N	36	111	35	182
		%	19.8	61.0	19.2	100
	Female	N	113	297	118	528
		%	21.4	56.2	22.3	100
Total		N	149	408	153	710
		%	21.0	57.5	21.5	100
2. How much are you satisfied with yourself?	Male	N	55	112	15	182
		%	30.2	61.5	8.2	100
	Female	N	180	296	52	528
		%	34.1	56.1	9.8	100
Total		N	235	408	67	710
		%	33.1	57.5	9.4	100

Table 6.4: life satisfaction of inmates based on gender distribution

Life satisfaction of inmates			Not at all	Moderately	Completely	Total
3. To what extent do you feel your life to be meaningful?	Male	N	71	104	7	182
		%	39.0	57.1	3.8	100
	Female	N	226	282	20	528
		%	42.8	53.4	3.8	100
Total		N	297	386	27	710
		%	41.8	54.4	3.8	100
4. How healthy is your physical environment?	Male	N	10	78	94	182
		%	5.5	42.9	51.6	100
	Female	N	31	239	258	528
		%	5.9	45.3	48.9	100
Total		N	41	317	352	710
		%	5.8	44.6	49.6	100

Table 6.4 shows the life satisfaction of inmates based on gender distribution. More than half of the inmates (54.4%) stated that their life was moderately meaningful. 41.8% of inmates not at all felt their life to be meaningful. Only 3.8% of inmates (27) felt that their life was completely meaningful.

Nearly half of the inmates (49.6%) stated that their physical environment was completely healthy. But 5.8% of inmates stated that their physical environment was not at all healthy and for 44.6% of inmates it was moderately healthy.

Table 6.5 Distribution of inmates by their activity and sociability

life satisfaction of inmates			Not at all	Moderately	Completely	Total
5. To what extent do you occupy in a useful activity?	Male	N	50	117	15	182
		%	27.5	64.3	8.2	100
	Female	N	172	315	41	528
		%	32.6	59.7	7.8	100
Total		N	222	432	56	710
		%	31.3	60.8	7.9	100
6. How much do you socialize with others?	Male	N	6	103	73	182
		%	3.3	56.6	40.1	100
	Female	N	28	268	232	528
		%	5.3	50.8	43.9	100
Total		N	34	371	305	710
		%	4.8	52.3	43.0	100

The above table (6.5) shows the distribution of inmates by their activity and sociability. Majority of inmates (60.8%) had occupied moderately in a useful activity.31.3% of inmates were not at all occupied in a useful activity. Only 7.9% of inmates had occupied completely in a useful activity.

More than half of inmates (52.3%) moderately socialized with others. 43.0% of inmates completely socialized with others and 4.8% of inmates were not at all socialized with others.

Table 6.6 Distribution of inmates by their level of satisfaction

Life satisfaction			Satisfied	Dissatisfied	Total
7. Are you satisfied with the relationship of inmates in the home?	Male	N	143	39	182
		%	78.6	21.4	100
	Female	N	353	175	528
		%	66.9	33.1	100
Total		N	496	214	710
		%	69.9	30.1	100
8. Are you satisfied with your family support?	Male	N	63	119	182
		%	34.6	65.4	100
	Female	N	164	364	528
		%	31.1	68.9	100
Total		N	227	483	710
		%	32.0	68.0	100

The above table (6.6) shows the life satisfaction of inmates in old age homes. 7) Majority of inmates (69.9%) were satisfied with the relationship of inmates in the home. But 30.1% of inmates were dissatisfied with their relationship. Majority of inmates (68.0%) were dissatisfied with their family support. Out of them, 65.4% were male inmates and 68.9% were female inmates. 32% of inmates were satisfied with their family support.

Table 6.7 Inmates' safety and condition of their living place

Life satisfaction			Satisfied	Dissatisfied	Total
9. Are you satisfied with the safety of your life?	Male	N	165	17	182
		%	90.7	9.3	100
	Female	N	484	44	528
		%	91.7	8.3	100
Total		N	649	61	710
		%	91.4	8.6	100
10. Are you satisfied with the condition of your living place?	Male	N	142	40	182
		%	78.0	22.0	100
	Female	N	423	105	528
		%	80.1	19.9	100
Total		N	565	145	710
		%	79.6	20.4	100

Table 6.7 reveals the satisfaction of inmates in the safety of their life and condition of their living place. 9) Majority of inmates (91.4%) in the home were satisfied with the safety of their life. Only 8.6% of inmates were dissatisfied with their safety.

10) 79.6% of inmates were satisfied with the condition of their living place. But 22% of male inmates and 19.9% of female inmates were dissatisfied with the condition of their living place.

Table 6.8 Condition of living place, Availability of transport facility and day to day information in old age homes

District	Old age home (OAH)	Are you satisfied with the condition of your living place?	Are you satisfied with the transport provided by home?	Are you satisfied with the availability of information in home?	Total Inmates N
		Satisfied			
Chennai	OAH -1	99%	99%	99%	84
	OAH -2	75%	63%	49%	81
	OAH -3	80%	20%	60%	40
	OAH -4	70%	77%	80%	30
	OAH -5	71%	85%	82%	27
Kanchee -puram	OAH -6	80%	59%	99%	49
	OAH -7	80%	60%	99%	15
	OAH -8	68%	42%	71%	38
	OAH -9	75%	44%	72%	32
	OAH -10	69%	42%	69%	26
Vellore	OAH -11	79%	34%	66%	38
	OAH -12	83%	38%	58%	24
	OAH -13	81%	33%	67%	21
	OAH -14	73%	40%	73%	15
	OAH -15	83%	34%	61%	36
Thiru -vallur	OAH -16	77%	55%	77%	62
	OAH -17	75%	58%	75%	12
	OAH -18	83%	50%	83%	6
	OAH -19	79%	57%	76%	66
	OAH -20	87%	63%	75%	8
Total		565	402	530	710
		80%	57%	75%	100 %

Table 6.9 Inmates' satisfaction in transport facility and day to day information

Life satisfaction			Satisfied	Dissatisfied	Total
11. Are you satisfied with the transport provided by home?	Male	N	101	81	182
		%	55.5	44.5	100
	Female	N	301	227	528
		%	57.0	43.0	100
Total		N	402	308	710
		%	56.6	43.4	100
12. How available to you is the information that you need in your day to day life?	Male	N	137	45	182
		%	75.3	24.7	100
	Female	N	393	135	528
		%	74.4	25.6	100
Total		N	530	180	710
		%	74.6	25.4	100

The above table (6.9) explains the availability of transport facility and day to day information to the inmates. 11) More than half (56.6%) of the inmates (402) were satisfied with the transport provided by the old age home. But, 43.4% of inmates (308) were dissatisfied with the transport facilities. 12) 74.6% of inmates (530) were satisfied with the availability of day to day information. But 25.4% of inmates (180) were dissatisfied with the availability of information.

Table 6.10 Distribution of inmates by their economic condition

Life satisfaction			Yes	No	Total
13. Have you enough money to meet your needs?	Male	N	24	158	182
		%	13.2	86.8	100
	Female	N	88	440	528
		%	16.7	83.3	100
Total		N	112	598	710
		%	15.8	84.2	100
14. Do you have a bank account in your own name?	Male	N	122	60	182
		%	67.0	33.0	100
	Female	N	334	194	528
		%	63.3	36.7	100
Total		**N**	**456**	**254**	**710**
		%	**64.2**	**35.8**	**100**

The above table (6.10) shows the distribution of inmates by their economic condition. 13) Majority of inmates (84.2%) did not have enough money to meet their needs. Only 15.8% of inmates (112) had enough money to meet their needs. Out of them, 13.2% were male inmates and 16.7% were female inmates. More than half of the inmates (64.2%) had a bank account in their own name. but 35.8% of inmates (254) did not have a bank account.

Table 6.11: District wise distribution of inmates and their relationship with children

District	Old age home (OAH)	Are you satisfied with the relationship of your children?					
		Very satisfied	Satisfied	Dissatis-fied	Very dissatisfied	No response	Not applica-ble
Chennai	OAH -1	0%	2%	8%	16%	17%	57%
	OAH -2	0%	5%	20%	26%	19%	30%
	OAH -3	0%	15%	10%	0%	0%	75%
	OAH -4	0%	27%	7%	0%	0%	66%
	OAH -5	0%	22%	7%	0%	0%	71%
Kancheepuram	OAH -6	0%	2%	10%	6%	2%	80%
	OAH -7	0%	13%	13%	7%	13%	54%
	OAH -8	0%	29%	18%	3%	0%	50%
	OAH -9	0%	50%	16%	0%	0%	34%
	OAH -10	4%	23%	15%	0%	0%	58%
Vellore	OAH -11	0%	13%	16%	5%	0%	66%
	OAH -12	0%	12%	21%	0%	0%	67%
	OAH -13	0%	5%	29%	0%	0%	66%
	OAH -14	0%	20%	7%	0%	0%	73%
	OAH -15	0%	6%	31%	0%	0%	63%
Thiru-vallur	OAH -16	0%	10%	13%	8%	0%	69%
	OAH -17	0%	0%	8%	33%	0%	59%
	OAH -18	0%	0%	33%	0%	0%	67%
	OAH -19	0%	11%	23%	14%	0%	52%
	OAH -20	0%	12%	0%	0%	0%	88%
Total		1 0.1%	90 12.7%	109 15.4%	59 8.3%	32 4.5%	419 59.0%

Majority of inmates (50%) in Kanchipuram District were satisfied with their children but, in Thiruvallur District (33%) dissatisfied with their children.

Table 6.12 Gender wise distribution of inmates and their relationship with children

Are you satisfied with the relationship of your children?		Gender		Total
		Male	Female	
Very satisfied	N	0	1	1
	%	0.0	0.2	0.1
Satisfied	N	26	64	90
	%	14.3	12.1	12.7
Dissatisfied	N	32	77	109
	%	17.6	14.6	15.4
Very dissatisfied	N	13	46	59
	%	7.1	8.7	8.3
No response	N	9	23	32
	%	4.9	4.4	4.5
Not applicable	N	102	317	419
	%	56.0	60.0	59.0
Total	N	182	528	710
	%	100	100	100

This table (6.12) explains the gender-wise distribution of inmates and their relationship with children. Only 0.1% of inmates were very satisfied with the relationship of their children. 12.7% of inmates (90) were satisfied with their children, 15.4% of inmates (109) were dissatisfied 8.3% of inmates were very dissatisfied and 4.5% of inmates did not respond to this question. Majority of inmates (59.0%) were not applicable to this question because they were single or did not have children.

Table 6.13 Gender wise distribution of inmates by their idea about old age home

Gender		Old age home is a good idea		Total
		Yes	No	
Male	N	179	3	182
	%	98.4	1.6	100.0
Female	N	524	4	528
	%	99.2	0.8	100.0
Total	N	703	7	710
	%	99.0	1.0	100.0

The above table (6.13) reveals the inmates' idea about old age home. Out of 182 male inmates, 98.4% of male inmates accepted the idea of old age homes. But, 1.6% of male inmates stated that old age home is not a good idea.

Out of 528 female inmates, 99.2% of female inmates welcomed the idea of old age home. Only 0.8% of female inmates opposed it. Based on gender distribution, male inmates more opposed the idea of old age home.

Table 6.14 explains the idea of inmates about old age home. Out of 710 inmates, 99% of inmates (703) stated that old age home is a good idea particularly for the helpless, destitute and marginalized elders. Only 1% of inmates (7) opposed the idea of old age home and stated that this idea encourages the children to admit their parents in old age home.

Table 6.14 Inmates' idea about old age home

District	Old age home (OAH)	Old age home is a good idea		Total Inmates N
		Yes	No	
Chennai	OAH -1 OAH -2 OAH -3 OAH -4 OAH -5	99% 100% 97% 96% 93%	1% 0% 3% 4% 7%	84 81 40 30 27
Kanchee -puram	OAH -6 OAH -7 OAH -8 OAH -9 OAH -10	100% 99% 100% 99% 99%	0% 1% 0% 1% 1%	49 15 38 32 26
Vellore	OAH -11 OAH -12 OAH -13 OAH -14 OAH -15	99% 98% 100% 99% 100%	1% 2% 0% 1% 0%	38 24 21 15 36
Thiru -vallur	OAH -16 OAH -17 OAH -18 OAH -19 OAH -20	99% 100% 100% 99% 100%	1% 0% 0% 1% 0%	62 12 6 66 8
Total		703	7	710
		99%	1%	100 %

6.3 Results of ANOVA with life satisfaction

Correlation of Life satisfaction with selected socio-demographic factors was analysed using ANOVA. Socio-demographic factors of gender, age, and district, were compared with satisfaction with Life Scale (SWLS).

1. From Table 6.15, the result of ANOVA revealed that there was no significant difference between gender with regard to life satisfaction [P=0.375] since the P-value was > 0.05 level of significance. Majority of male inmates (64.2%) and the majority of female inmates (59.7%) secured < 20 scores in life satisfaction.

Table 6.15 Correlation of Life satisfaction with selected socio-demographic factors (1)

Socio-demographic factors	Life satisfaction (Satisfaction with life scale)					N=710 Total
	Dissatis-fied	Slightly dissatisfied	Neutral	Slightly satisfied	Satisfied	
Score	10 - 14	15 – 19	20	21 - 25	26 - 30	
1. Gender : P = 0.375						
Male	23(12.6)	94 (51.6)	17 (9.3)	44 (24.2)	4 (2.2)	182 (100)
Female	69(13.1)	246 (46.6)	43 (8.1)	168 (31.8)	2 (0.4)	528 (100)
2. Age : P = 0.106						
60-69	20 (15.7)	69 (54.3)	7 (5.5)	31 (24.4)	0 (0.0)	127 (100)
70-79	37 (12.1)	144 (46.9)	39 (12.7)	85 (27.7)	2 (0.7)	307 (100)
80-89	31 (12.7)	111 (45.5)	12 (4.9)	86 (35.2)	4 (1.6)	244 (100)
90-99	4 (12.5)	16 (50.0)	2 (6.2)	10 (31.2)	0 (0.0)	32 (100)
3. District : P = 0.000**						
Chennai	59 (22.5)	121 (46.2)	5 (1.9)	74 (28.2)	3 (1.1)	262 (100)
Kanchee-puram	33 (20.6)	66 (41.2)	13 (8.1)	47 (29.4)	1 (0.6)	160 (100)
Vellore	0 (0.0)	68 (50.7)	19 (14.2)	45 (33.6)	2 (1.5)	134 (100)
Thiruvallur	0 (0.0)	85 (55.2)	23 (14.9)	46 (29.9)	0 (0.0)	154 (100)

Note: a) None of them stated 'Extremely dissatisfied' score (5 – 9)
b) None of them stated 'Extremely satisfied' score (31 – 35)
c) ** denotes significant at 1% level
d) '( )' shows the percentage of the number

2. According to the age factor, P-value was > 0.05 level of significance with regard to the life satisfaction of inmates in old age homes. Result reveals that all age groups of inmates were dissatisfied with their life satisfaction. Hence, it is

assumed that there was no significant difference between age groups and life satisfaction of inmates.

3. It was evident from the result of ANOVA that there was a highly significant difference between districts of Tamilnadu with regard to the Life satisfaction of Inmates and the P-value was <0.001 level. In Chennai and Kancheepuram districts, more inmates were dissatisfied than Vellore and Thiruvallur districts inmates. In this research, the majority of paid old age homes have been situated in Chennai and Kancheepuram districts.

Table 6.16 Correlation of Life satisfaction with selected socio-demographic factors (2)

Socio demographic factors	Life satisfaction (Satisfaction with life scale)					N=710 Total
	Dissatis -fied	Slightly dissatisfied	Neutral	Slightly satisfied	Satis -fied	
Score	10 - 14	15 – 19	20	21 - 25	26 - 30	
4.Marital status : P = 0.187						
Single	34 (13.5)	121 (48.0)	21 (8.3)	72 (28.6)	4 (1.6)	252(100)
Married	3 (5.8)	19 (36.5)	12 (23.1)	18 (34.6)	0 (0.0)	52(100)
Widowed	49 (12.8)	192 (50.1)	26 (6.8)	114(29.8)	2 (0.5)	383(100)
Separated	5 (25.0)	6 (30.0)	1 (5.0)	8 (40.0)	0 (0.0)	20(100)
Divorced	1 (33.3)	2 (66.7)	0 (0.0)	0 (0.0)	0 (0.0)	3(100)
5.Type of home : P = 0.000**						
Free	43 (11.3)	153 (40.3)	33 (8.7)	148 (38.9)	3 (0.8)	380(100)
Paid	49 (17.9)	156 (57.1)	18 (6.6)	48 (17.6)	2 (0.7)	273(100)
Free-cum-Paid	0 (0.0)	31 (54.4)	9 (15.8)	16 (28.1)	1 (1.8)	57(100)
6.Education : P = 0.733						
Illiterate	4 (10.3)	23 (59.0)	5 (12.8)	6 (15.4)	1 (2.6)	39(100)
Primary school	20 (15.7)	52 (40.9)	8 (6.3)	47 (37.0)	0 (0.0)	127(100)
Middle school	22 (11.2)	93 (47.4)	18 (9.2)	62 (31.6)	1 (0.5)	196(100)
High school	28 (17.7)	74 (46.8)	11 (7.0)	43 (27.25)	2 (1.3)	158(100)
Intermediate	14 (11.5)	59 (48.4)	12 (9.8)	36 (29.5)	1 (0.8)	122(100)
Graduate	2 (4.2)	29 (60.4)	3 (6.2)	13 (27.1)	1 (2.1)	48(100)
Professional	2 (11.8)	7 (41.2)	3 (17.6)	5 (29.4)	0 (0.0)	17(100)
Others	0 (0.0)	3(100)	0 (0.0)	0 (0.0)	0 (0.0)	3(100)

Note: '( )' shows the percentage of the number

Correlation of Life satisfaction with selected socio-demographic factors was analysed using ANOVA. Socio-demographic factors of marital status, type of old age home and education were compared with Satisfaction With Life Scale Scores (SWLS).

4. Table 6.16 shows the result of ANOVA applied between the marital statuses of inmates with regard to the life satisfaction of inmates. It was observed that there was no statistical difference between marital status and life satisfaction of inmates since the P-value was > 0.05 level of significance (P = 0.187). Based on the above finding it was concluded that the marital status of inmates in old age home did not have an impact on life satisfaction of inmates.
5. The result of ANOVA revealed that there was a strong significant difference between the type of old age homes with regard to the life satisfaction of inmates since the P-value was <0.001 level of significance. Free old age home inmates had secured high scores in life satisfaction compared with paid home and Free-cum-paid home inmates. Majority of free home inmates satisfied with their life.
6. One of the socio-demographic factors of Education was not significantly associated (P= 0.733) with life satisfaction of inmates.

Correlation of life satisfaction with selected living environment factors had been calculated by P-Value. Table 6.17 shows the selected factors of; Type of old age home rooms, the number of roommates, length of stay in old age home and living environment of the home. It also revealed the significant difference between Life satisfaction and living environment variables.

7. It was observed that there was a highly significant correlation between the types of rooms in old age home with regard to the life satisfaction of inmates since the P-value was <0.001. Inmates in a single occupied room, twin sharing and triple sharing room were more satisfied than inmates in the dormitories.
8. It was described that the variable number of roommates was significantly (P = 0.001) associated with Life satisfaction of inmates. Majority of inmates (367) were living with 1 to 3 numbers of roommates in this study.
9. The result from table 6.17 revealed that there was no significant difference (P = 0.333) between the length of stay of inmates in old age home with regard to the Life satisfaction of inmates since the P-value was > 0.05 Level.

10. The result revealed that there was a highly significant correlation between living environment and life satisfaction of inmates since the P-value was <0.011 level. Out of 710 inmates, the majority of (352) inmates stated that their living environment was completely good.

Table 6.17 Correlation of Life satisfaction with selected living environment factors

Living environment	Life satisfaction (Satisfaction with life scale)					N=710 Total
	Dissatis -fied	Slightly dissatisfied	Neutral	Slightly satisfied	Satisfied	
Score	10 - 14	15 – 19	20	21 - 25	26 - 30	
7.Type of rooms : P = 0.000**						
Dormitory	35 (10.2)	149(43.4)	32 (9.3)	124 (36.2)	03 (0.9)	343 (100)
Single occupy	09 (24.3)	24(64.9)	01 (2.7)	3 (8.1)	0 (0.0)	37 (100)
Twin sharing	37 (14.5)	12 (49.8)	21 (8.2)	67 (26.3)	3 (1.2)	255 (100)
Triple sharing	11 (14.7)	40(53.3)	6 (8.0)	18 (24.0)	0 (0.0)	75 (100)
8.Roommates : P = 0.001**						
1 to 3	56 (15.3)	191(52.0)	29 (7.9)	88 (24.0)	3 (0.8)	367 (100)
4 to 6	21 (8.4)	113(45.4)	26(10.4)	88 (35.3)	1 (0.4)	249 (100)
Above 6	15 (16.0)	36(38.3)	5 (5.3)	36 (38.3)	2 (2.1)	94 (100)
9.Length of stay: P = 0.333						
< 1 year	17 (12.4)	67(48.9)	14 (10.2)	38 (27.7)	1 (0.7)	137 (100)
1 to 5 years	46 (13.3)	161(46.4)	33 (9.5)	103 (29.7)	4 (1.2)	347 (100)
5 to 10 years	23 (12.4)	99(53.2)	11 (5.9)	52 (28.0)	1 (0.5)	186 (100)
> 10 years	6 (15.0)	13(32.5)	2 (5.0)	19 (47.5)	0 (0.0)	40 (100)
10. living environment is good: P = 0.003**						
Not at all	0 (0.0)	36(87.8)	0 (0.0)	5 (12.2)	0 (0.0)	41 (100)
Moderately	35(11.0)	133(42.0)	39 (12.3)	106 (33.4)	4 (1.3)	317 (100)
Completely	57 (16.2)	171(48.6)	21 (6.0)	101 (28.7)	2 (0.6)	352 (100)

Table 6.18 shows the correlation of social support factors with life satisfaction of inmates. Selected factors of a) Visit of relatives, b) Outside visit of inmates, c) Visit of family members, d) Socialize with others and e) Inmates - Inmates relationship were analysed with the score of satisfaction with life scale.

11. The results revealed that there was a significant difference (P = 0.033) between the visit of relatives in old age home and life satisfaction of inmates since the P-value was < 0.05 Level of significant.
12. There was a strong correlation between outside visits of inmates with regards to the life satisfaction of inmates since the P-value was 0.001.
13. Table 6.18 also shows the result between the family's visits to the old age home with regard to the life satisfaction of inmates and there was a strong correlation between them since the P-value was <0.001.

Table 6.18 Correlation of Life satisfaction with selected social support factors (1)

Social support factors	Life satisfaction (Satisfaction with life scale)					N=710 Total
	Dissatis -fied	Slightly dissatisfied	Neutral	Slightly satisfied	Satis -fied	
Score	10 - 14	15 – 19	20	21 - 25	26 - 30	
11.Visit of relatives : P = 0.033*						
Allowed	88 (14.3)	295 (47.9)	47 (7.6)	181 (29.4)	5 (0.8)	616 (100)
Not allowed	4 (4.3)	45 (47.9)	13 (13.8)	31 (33.0)	1 (1.1)	94 (100)
12.Outside visit of inmates : P = 0.001**						
Allowed	45 (10.0)	207 (45.8)	43 (9.5)	152 (33.6)	5 (1.1)	452 (100)
Not allowed	47 (18.2)	133 (51.6)	17 (6.6)	60 (23.3)	1 (0.4)	258 (100)
13.Family's visit: P = 0.000**						
Once a year	8 (20.5)	29 (74.4)	1 (2.6)	1 (2.6)	0 (0.0)	39 (100)
Seldom	26 (10.2)	136 (53.3)	17 (6.7)	72 (28.2)	4 (1.6)	255 (100)
Never	35 (10.7)	143 (43.7)	40 (12.2)	107 (32.7)	2 (0.6)	327 (100)
Not applicable	23 (25.8)	32 (36.0)	2 (2.2)	32 (36.0)	0 (0.0)	89 (100)
14.Socialize with others: P = 0.538						
Not at all	7 (20.6)	13 (38.2)	0 (0.0)	13 (38.2)	1 (2.9)	34 (100)
Moderately	41 (11.1)	195 (52.6)	35 (9.4)	97 (26.1)	3 (0.8)	371 (100)
Completely	44 (14.4)	132 (43.3)	25 (8.2)	102 (33.4)	2 (0.7)	305 (100)
15.Satisfaction with inmates: P = 0.119						
Satisfied	70 (14.1)	243 (49.0)	45 (9.1)	134 (27.0)	4 (0.8)	496 (100)
Dissatisfied	22 (10.3)	97 (45.3)	15 (7.0)	78 (36.4)	2 (0.9)	214 (100)

14. In old age homes, the majority of inmates (371) were moderately socialized with others. Result revealed that [P = 0.538] there was no correlation between life satisfaction and socialize with others since the P-value was > 0.05 level of significance.

15. Out of 710 inmates, the majority of inmates (496) were satisfied with other inmates' relationship in old age home. It was found that there was no significant relation (P=0.119) between life satisfaction and other inmates' relationship.

Table 6.19 Correlation of Life satisfaction with selected social support factors (2)

Social support factors	Life satisfaction (Satisfaction with life scale)					N=710 Total
	Dissatisfied	Slightly dissatisfied	Neutral	Slightly satisfied	Satisfied	
Score	10 - 14	15 – 19	20	21 - 25	26 - 30	
16.Family support: P = 0.000**						
Satisfied	52 (22.9)	95 (41.9)	25 (11.0)	54 (23.8)	1 (0.4)	227 (100)
Dissatisfied	40 (8.3)	245 (50.7)	35 (7.2)	158 (32.7)	5 (1.0)	483 (100)
17.Safety of inmates: P = 0.100						
Satisfied	82 (12.6)	303 (46.7)	56 (8.6)	202 (31.1)	6 (0.9)	649 (100)
Dissatisfied	10 (16.4)	37 (60.7)	4 (6.6)	10 (16.4)	0 (0.0)	61 (100)
18.Living place: P = 0.922						
Satisfied	72 (12.7)	274 (48.5)	49 (8.7)	165 (29.2)	5 (0.9)	565 (100)
Dissatisfied	20 (13.8)	66 (45.5)	11 (7.6)	47 (32.4)	1 (0.7)	145 (100)
19. Transport facility: P = 0.043*						
Satisfied	52 (12.9)	180 (44.8)	29 (7.2)	138 (34.3)	3 (0.7)	402 (100)
Dissatisfied	40 (13.0)	160 (51.9)	31 (10.1)	74 (24.0)	3 (1.0)	308 (100)
20.Availability of information: P = 0.006**						
Satisfied	61 (11.5)	242 (45.7)	52 (9.8)	171 (32.3)	4 (0.8)	530 (100)
Dissatisfied	31 (17.2)	98 (54.4)	8 (4.4)	41 (22.8)	2 (1.1)	180 (100)

Note: a) None of them stated 'Extremely dissatisfied' score (5 – 9)

b) None of them stated 'Extremely satisfied' score (31 – 35)

c) ** denotes significant at 1% level

d) * denotes significant at 5% level

e) '( )' shows the percentage of the number

Table 6.19 shows the correlation of life satisfaction with selected social support factors of a) Family support, b) Safety of inmates, c) Living place, d) Transport facility and e) Availability of information.

16. Result revealed that there was a strong correlation between family supports with regard to the life satisfaction of inmates since the P-value was < 0.001 level of significance.
17. It was found that there was no significant difference between the safety of inmates with regard to the life satisfaction scores and the P-value was 0.100.
18. Out of 710 inmates, the majority of inmates (565) were satisfied with their living place (Old age home). Result revealed that there was no correlation between the living place of inmates with life satisfaction scores (P = 0.922).
19. It was found that there was a correlation between the availability of transport facilities in old age home with regards to their life satisfaction of inmates since the P-value was (0.043) <0.05.
20. Table 6.19 also shows the result of ANOVA applied between the accessibility of information to the inmates and life satisfaction of inmates. There was a highly significant relationship between them and the P-value was 0.006. Many inmates were interested to watch the news in television and the majority of the inmates (530) were satisfied with the availability of information in Old age Home.

Table 6.20 revealed the association of life satisfaction with selected economic support factors. The major economic support factors are a) Sources of income of inmates, b) Savings of inmates and c) Assets earned by inmates.

21. It was found that there was a strong significant (P < 0.001) relation between sources of income of inmates and life satisfaction of inmates. Economic condition is one of the most influential factors of life satisfaction. Out of 710 inmates, the majority of inmates (386) did not have any sources of income and out of them, only 37.8% were slightly satisfied with their life.
22. The results revealed that there was a significant difference (P = 0.002) between the savings of inmates and life satisfaction of inmates. Out of 710 inmates, only 204 inmates had some savings with them. Majority of free home inmates did not have any savings.
23. It was also found that there was no correlation between assets of inmates and life satisfaction scores since the P-value was > 0.05 level of significance.

24. Out of 710 inmates, 640 did not receive any pension in old age home. Only 70 inmates were receiving a pension from various Government schemes. There was a correlation between pension received and life satisfaction of inmates since the P-value was (0.011) <0.05 level of significance.

Table 6.20 Correlation of Life satisfaction with selected economic support factors

Economic support factors	Life satisfaction (Satisfaction with life scale)					N=710 Total
	Dissatisfied	Slightly dissatisfied	Neutral	Slightly satisfied	Satisfied	
Score	10 - 14	15 – 19	20	21 - 25	26 - 30	
21.Sources of income: P = 0.000**						
Son	21(18.8)	60(53.6)	10(8.9)	21(18.8)	0(0.0)	112(100)
Daughter	7(15.2)	25(54.3)	5(10.9)	9(19.6)	0(0.0)	46(100)
Relatives	12(14.0)	57(66.3)	2(2.3)	15(17.4)	0(0.0)	86(100)
Pension	13(18.6)	28(40.0)	7(10.0)	22(31.4)	0(0.0)	70(100)
Property	2 (20.0)	5 (50.0)	0 (0.0)	3 (30.0)	0 (0.0)	10 (100)
None	39(10.1)	165(42.7)	36(9.3)	146(37.8)	0 (0.0)	386 (100)
22.Savings : P = 0.002**						
Yes	29 (14.2)	117 (57.4)	14 (6.9)	41 (20.1)	3 (1.5)	204 (100)
No	63 (12.5)	223 (44.1)	46 (9.1)	171 (33.8)	3 (0.6)	506 (100)
23.Assets : P = 0.887						
Land	0 (0.0)	2 (66.7)	0 (0.0)	1 (33.3)	0 (0.0)	3 (100)
House	2 (40.0)	2 (40.0)	0 (0.0)	1 (20.0)	0 (0.0)	5 (100)
Business	0 (0.0)	1 (50.0)	0 (0.0)	1 (50.0)	0 (0.0)	2 (100)
None	90 (13.0)	335 (47.9)	60 (8.6)	209 (29.9)	6 (0.9)	700 (100)
24.Receive pension: P = 0.011*						
Yes	11 (15.7)	27 (38.6)	7 (10.0)	22 (31.4)	3 (4.3)	70 (100)
No	81 (12.7)	313 (48.9)	53 (8.3)	190 (29.7)	3 (0.5)	640 (100)

Note: a) None of them stated 'Extremely dissatisfied' score (5 – 9)
b) None of them stated 'Extremely satisfied' score (31 – 35)
c) ** denotes significant at 1% level
d) * denotes significant at 5% level
e) '( )' shows the percentage of the number

Table 6.21 Correlation of Life satisfaction with selected health status factors

Health status	Life satisfaction (Satisfaction with life scale)					N=710 Total
	Dissatisfied	Slightly dissatisfied	Neutral	Slightly satisfied	Satisfied	
Score	10 - 14	15 – 19	20	21 - 25	26 -30	
25.Balanced diet: P = 0.000**						
Available	89 (14.0)	303 (47.6)	46 (7.2)	195 (30.6)	4 (0.6)	637(100)
Not available	3 (4.1)	37 (50.7)	14(19.2)	17 (23.3)	2 (2.7)	73 (100)
26.Exercise facilities: P = 0.521						
Available	54 (14.1)	177 (46.3)	28 (7.3)	120 (31.4)	3 (0.8)	382 (100)
Not available	38 (11.6)	163 (49.7)	32 (9.8)	92 (28.0)	3 (0.9)	328 (100)
27.Medical facilities: P = 0.001**						
Available	69 (12.4)	247 (44.4)	49 (8.8)	186 (33.5)	5 (0.9)	556 (100)
Not available	23 (14.9)	93 (60.4)	11 (7.1)	26 (16.9)	1 (0.6)	154 (100)
28.Psychological abuse: P = 0.824						
Yes	39 (13.4)	132 (45.4)	27 (9.3)	90 (30.9)	3 (1.0)	291 (100)
No	53 (12.6)	208 (49.6)	33 (7.9)	122 (29.1)	3 (0.7)	419 (100)
29.Useful activities: P = 0.000**						
Not at all	43 (19.4)	89 (40.1)	30(13.5)	56 (25.2)	4 (1.8)	222 (100)
Moderately	40 (9.3)	223 (51.6)	30 (6.9)	137 (31.7)	2 (0.5)	432 (100)
Completely	9 (16.1)	28 (50.0)	0 (0.0)	19 (33.9)	0 (0.0)	56 (100)

Note: a) None of them stated 'Extremely dissatisfied' score (5 – 9)
b) None of them stated 'Extremely satisfied' score (31 – 35)
c) ** denotes significant at 1% level

Table 6.21 reveals the correlation of life satisfaction of inmates with selected health status factors. The vital factors of health status are a) Availability of balanced diet, b) Exercise facilities, c) Medical facilities, d) Psychological abuse and e) Useful activities.

25. There was a strong correlation between the availability of balanced diet in old age home with regard to the life satisfaction of inmates (P-value < 0.001).

26. It was also found that there was no relation between the availability of exercise facilities and life satisfaction scores [P = 0.521]. Some Old age homes conduct yoga classes to the inmates inside their homes.

27. There was a significant difference between life satisfaction of inmates [P = 0.001] with regards to the availability of medical facilities in their home. Majority of old age homes provide moderate medical facilities to the inmates. Particularly Free homes provide more medical facilities to the inmates than paid homes.

28. The results revealed that there was no correlation [P = 0.824] between psychological abuse and life satisfaction of inmates.

29. It was also observed that there was a strong significant difference between useful activities of inmates with regard to life satisfaction since the P-value was < 0.001.

Table 6.22 Correlation of Life satisfaction with Oxford happiness scale

Oxford happiness scale (1-6)	Life satisfaction (Satisfaction with life scale)					Total
	Dissatisfied	Slightly dissatisfied	Neutral	Slightly satisfied	Satisfied	
Score	10 - 14	15 - 19	20	21 - 25	26 - 30	
Not happy (1-2)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Somewhat Unhappy (2-3)	49(16.3)	156(51.8)	18 (6.0)	77 (25.6)	1 (0.3)	301(100)
Not particularly happy (3-4)	35(10.7)	155(47.4)	36(11.0)	101(30.9)	0 (0.0)	327(100)
Somewhat happy (4)	8 (10.1)	28 (35.4)	6 (7.6)	33 (41.8)	4 (5.1)	79 (100)
Rather happy (4-5)	0 (0.0)	1 (33.3)	0 (0.0)	1 (33.3)	1 (33.3)	3 (100)
Very happy (5-6)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Too happy (6)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
P-Value	**0.000****					

Note: a) None of them stated 'Extremely dissatisfied' score (5 – 9)

b) None of them stated 'Extremely satisfied' score (31 – 35)

c) ** denotes significant at 1% level

d) '( )' shows the percentage of the number

Table 6.22 shows the correlation of Life satisfaction of inmates with Oxford happiness scale scores. There was a strong correlation between life satisfaction of inmates with regards to their level of happiness since the P-value was < 0.001 level of significance. Out of 710 inmates, the majority of them (327) were not particularly happy (Score 3 – 4). These inmates were 58.1% dissatisfied with their life satisfaction.

CHAPTER VII

Living environment of inmates in old age home

7.1 Living environment

Older people have a clear relationship between the living environment they inhabit and their feelings of belonging are not necessarily tied to legal ownership or long occupation (Davidson Kendig Stephen and Merril, 1993). Home, however, is much more than a physical environment. The home environment is conceptualized as having three primary modes of experience (Osawld and Wahl, 2005).

1. Physical home - It refers to the space that can be measured and is shaped by function, culture and history (Steward, 2000).
2. The social home - Encompassing relationships with significant others, such as family member, who may often inhabit the same physical environment.
3. The personal home - is a place of self-expression identity and personal control, a central reference point in a person's life encapsulating feelings of familiarity, security and belonging.

Home, as a physical, social, and personal experience, occurs within a temporal framework, reflecting the dynamic and changing nature of the meaning of home for individuals over time. Peoples' relationship with their home has histories, futures, recurrences, and rhythms that affect their current experience and meaning (Dovey, 1985; Werner et al., 1985). The meaning of home as a place to strengthen and secure important relationships was a theme that emerged strongly from this study. For some participants, social relationships were of more importance and high value than other aspects of the home such as comfort, ease of access, and functionality. Relationships that extend outside of the home were as highly valued as those within the home.

Elderly people becoming dependent in activities of daily living increasingly seek social and community help, finally being forced to enter into old age home. There has been increased recognition in the importance of the home environment to the health, well-being and independence of older people (Australian Bureau of Statistics 2005). An important part of institutional care from social perspective represents the need to protect

frail people and offer them a safe place to live (Ramovs 2004). The need to protect was addressed mainly from the health point of view but in some cases, it could also refer to maltreatment.

Quality of caring in a living environment

Inmates often evaluated the quality of caring through the willingness of staff to communicate with them. They desired to express their wishes, needs and also some criticism. A human emotional relationship is often noticed by behaviour or responses of staff members. Nursing staff should be careful expressing these signs and should always have this on their mind when caring or accompanying elderly residents. The main category of quality institutional elderly care was described as institutional custody applied with good personal hygiene, quality food and safe medication. Inmates also expected individual approach by sufficient staff, organizing desired social or meaningful activities or events comfortable and physically safe living environment.

Residents of old age homes noticed and were aware of the numerical inadequacy of staffs. In their description of quality institutional elderly care, they often expressed the problem of less staff working on the home. Most of them believed that enough staff members could offer better care and room visits could be longer. To assure the quality of care for all residents a sufficient number of staffs must be available. Relatives in the majority were satisfied with basic care, they had complained about the frequency or duration of treatments.

Comfortable and safe environment comprised a clean environment, comfortable furniture and physical safety. Relatives of paid home inmates were concerned about a clean environment than elderly residents. Suitable environment and comfortable furniture makes residence pleasant to live in, offers adequate security and self-confidence by moving around the living room and bathroom. Inmates expect staff members to organize plenty of activities to improve quality of life in institutional custody, such as morning exercises, cooking gatherings or other activities that would attract many residents. Neglect of care comprised insufficient hygiene, lack of physical activities, fast feeding and devaluation of human dignity should be avoided in the institutional care.

The main characteristics of the living environment in old age homes are followed;

Table 7.1 Subcategories of old age homes

District	Subcategories of old age homes			Total number of old age homes
	Men & Women	Only for Women	Only for Men	
Chennai	4	1	0	5
Kanchipuram	5	0	0	5
Vellore	4	1	0	5
Thiruvallur	4	1	0	5
Total	17	3	0	20

The above table (7.1) shows the number of sub-categories of old age homes. There are three subcategories of old age homes. They are 1) old age home for men and women, 2) Home for only women and 3) Home for only men. Out of 20 homes, 17 homes have established for men and women inmates. Three homes were running only for women inmates. The third subcategory of the home was not included in this research work.

Table 7.2 Type of hospitals visited by the inmates

District	Hospital facilities near old age homes (Number of homes)				Total number of old age homes
	Private hospital	%	Government hospital	%	
Chennai	5	25	0	0	5
Kanchipuram	1	5	4	20	5
Vellore	1	5	4	20	5
Thiruvallur	2	10	3	15	5
Total	9	45	11	55	20

The above table 7.2 explains the type of hospital visited by the inmates. Only 45% of old age home inmates visited the private hospitals and 55% of old age home inmates visited the Government hospitals.

Table 7.3 describes that majority of homes (70%) provide medicines to their inmates for fever, cough, cold, knee pain, headache and etc. In some homes (30%) medicines were not available. Majority of Free homes provide medicines to their inmates but not paid homes.

Table 7.3 Availability of medicines in old age homes

District	Availability of medicines (Number of homes)				Total number of old age homes
	Available	%	Not available	%	
Chennai	3	15	2	10	5
Kanchipuram	3	15	2	10	5
Vellore	4	20	1	5	5
Thiruvallur	4	20	1	5	5
Total	14	70	6	30	20

Table 7.4 Availability of Walker / Wheelchair in old age homes

District	Availability of Walker / Wheelchair (Number of homes)				Total number of old age homes
	Available	%	Not available	%	
Chennai	3	15	2	10	5
Kanchipuram	2	10	3	15	5
Vellore	3	15	2	10	5
Thiruvallur	2	10	3	15	5
Total	10	50	10	50	20

Out of 20 homes, 50% of homes provide walker/wheelchair to their inmates. In another 50% of homes, Walker/ Wheelchair were not available. Majority of free homes provide Walker / Wheelchair to their inmates.

Table 7.5 Distribution of old age homes by their social activities

District	Organize Social activities (Number of homes)				Total number of old age homes
	Organize	%	Not organize	%	
Chennai	2	10	3	15	5
Kanchipuram	2	10	3	15	5
Vellore	3	15	2	10	5
Thiruvallur	2	10	3	15	5
Total	9	45	11	55	20

The above table (7.5) shows the number of old age homes by their social activities. Out of 20 homes, 9 homes organize social activities to their inmates. In festival season they conduct small competition programs. Some homes organize a picnic, pilgrimage and outside visit to their inmates. Some homes organize social

activities with school and college students in their homes. Majority of free homes organize social activities compare to paid homes. Some social activities were asked, to break the monotony and to have some fun or joy. Active life was described by social activities, sociability and organization of social events. Inmates would like to take part in different activities that stimulate physical and mental health, like morning exercise, playing cards or party games.

Table 7.6 Type of food provided in old age homes

District	Type of food in homes (Number of homes)				Total number of old age homes
	Vegetarian	%	Vegetarian & Non-vegetarian	%	
Chennai	3	15	2	10	5
Kanchipuram	4	20	1	5	5
Vellore	2	10	3	15	5
Thiruvallur	5	25	0	0	5
Total	14	70	6	30	20

Majority of old age homes (70%) provide vegetarian food to the inmates. Only 30% of old age homes provide vegetarian and non-vegetarian food to their inmates.

Table 7.7 Availability of balanced diet in Homes

District	Balanced diet (Number of homes)				Total number of old age homes
	Available	%	Not available	%	
Chennai	2	10	3	15	5
Kanchipuram	2	10	3	15	5
Vellore	2	10	3	15	5
Thiruvallur	3	15	2	10	5
Total	9	45	11	55	20

The above table (7.7) shows the availability of a balanced diet to the inmates. Out of 20 homes, 9 homes (45%) provide a balanced diet to their inmates along with vegetables. 55% of homes cannot provide a balanced diet for their inmates. Some of the paid home inmates stated that they could not get a balanced diet in their homes. Quality food was one of the main issues of quality institutional elderly care expressed by relatives. Some inmates were unsatisfied with served food and suggested that homes

should also consider contemporary nutrition trends. They also expressed the need for enough liquids at hand and proper feeding of handicapped residents.

Table 7.8 Availability of fruits in homes

District	Availability of fruits (Number of homes)				Total number of old age homes
	Available	%	Not available	%	
Chennai	2	10	3	15	5
Kanchipuram	1	5	4	20	5
Vellore	1	5	4	20	5
Thiruvallur	0	0	5	25	5
Total	4	20	16	80	20

Out of 20 homes, only 4 homes provide fruits to their inmates. All other homes (80%) did not provide fruits to their inmates. Even paid homes couldn't provide fruits to their inmates. If needed, inmates had to pay separately for fruits. The inmates wished to get served quality food and especially enough fruits. Some of them were unsatisfied with served food because staff members were not interested in what they like to eat.

Table 7.9 Availability of common hall and worship place in old age homes

District	Common Hall				Worship place			
	Available	%	Not available	%	Available	%	Not available	%
Chennai	5	25	0	0	3	15	2	10
Kanchipuram	4	20	1	5	3	15	2	10
Vellore	3	15	2	10	3	15	2	10
Thiruvallur	2	10	3	15	3	15	2	10
Total	14	70	6	30	12	60	8	40

The living environment takes place a vital role in the life satisfaction of inmates. The above table 7.9 shows the availability of a common hall and separate worship place in old age homes. 70% of homes had a common hall (living area) separately. 30% of homes did not have a common hall and they had only dormitory rooms to live. For many of the people interviewed, space was an important factor in their enjoyment of home because they identified the need to have space. Majority of homes (60%) had separate worship place to the inmates. But 40% of homes had not got separate worship place and they had only dormitory rooms to live. Maintaining a

comfortable physical environment, particularly by managing the discomfort of heat and having pleasing aesthetics, was also an issue for many participants.

Table 7.10 Availability of dining hall and storerooms in old age homes

District	Dining Hall				Storeroom			
	Available	%	Not available	%	Available	%	Not available	%
Chennai	2	10	3	15	3	15	2	10
Kanchipuram	2	10	3	15	3	15	2	10
Vellore	3	15	2	10	3	15	2	10
Thiruvallur	2	10	3	15	3	15	2	10
Total	9	45	11	55	12	60	8	40

Large old age homes had a separate dining hall and storeroom. The above table (7.10) shows the availability of dining hall and storerooms in old age homes. Majority of homes covered in this study were large old age homes. Out of 20 homes, 45% of homes had a dining hall. But 55% of homes had not got the dining hall separately. The food was distributed to their bedrooms /dormitories. 60% of homes had got storerooms in their homes. 40% of homes had not got separate storeroom and they kept groceries in the kitchen.

Table 7.11 Availability of attached restroom in old age homes

District	Availability of attached restroom				Total number of old age homes
	Available	%	Not available	%	
Chennai	2	10	3	15	5
Kanchipuram	1	5	4	20	5
Vellore	1	5	4	20	5
Thiruvallur	0	0	5	25	5
Total	4	20	16	80	20

The above (7.11) table explains the availability of attached restroom in old age homes. Few old age homes (20%) had attached restroom facilities to the inmates. 80% of homes had not got attached restroom facilities.

Table 7.12 illustrates the availability of fire extinguisher in old age homes. Out of 20 homes, 50% of homes had got a fire extinguisher in their homes. Another 50% of homes did not have a fire extinguisher for emergency purpose.

Table 7.12 Availability of fire extinguisher in old age homes

District	Availability of Fire extinguisher (Number of homes)				Total number of old age homes
	Available	%	Not available	%	
Chennai	3	15	2	10	5
Kanchipuram	2	10	3	15	5
Vellore	2	10	3	15	5
Thiruvallur	3	15	2	10	5
Total	10	50	10	50	20

Table 7.13 Outside visit of inmates

District	Outside visit of inmates (Number of homes)				Total number of old age homes
	Allow	%	Not allow	%	
Chennai	3	15	2	10	5
Kanchipuram	2	10	3	15	5
Vellore	2	10	3	15	5
Thiruvallur	2	10	3	15	5
Total	9	45	11	55	20

The above table (7.13) highlights the outside visit of inmates. Majority of homes (55%) did not allow their inmates to go for an outside visit. Many rules are followed by the management to send the inmates for an outside visit. Only 9 homes (45%) allowed their inmates to go outside for shopping, to meet their relatives/ friends and to do social activities.

Some paid home inmates expect to preserve their contact with the outside world through organized social events, religious festivals like Diwali, Christmas, etc. They also expressed expectations for cultural events like theatre, literature evenings and parties. Some inmates have difficulties to come in touch with other residents due to new or unknown environment. This study supports the often expressed assumption that most people wish to remain in their home as they age, preferably until they die or at least are not able to manage for themselves any longer.

Table 7.14 describes the availability of Garden in old age homes. Out of 20 homes, the majority of homes (65%) had garden inside their campus. Some inmates were very much attached to the garden. Every day they spend some time to take care of the plants. 35% of homes did not have a garden. Inmates spoke of gardens they had

created, improvements they had performed, and furnishings, decorations, and personal objects they had installed, all of which made their dwelling place home to them. Control over the home environment was also a theme that emerged related to this.

Table 7.14 Availability of Garden in old age homes

District	Availability of Garden (Number of homes)				Total number of old age homes
	Available	%	Not available	%	
Chennai	2	10	3	15	5
Kanchipuram	2	10	3	15	5
Vellore	4	20	1	5	5
Thiruvallur	5	25	0	0	5
Total	13	65	7	35	20

7.2 Results of ANOVA with living environment of inmates

Table 7.15 shows the result of ANOVA applied between living environments of inmates with selected socio-demographic factors (Gender, Age, Type of home, Sources of income and Type of room).

a) It was observed that there was no statistical difference between gender and living environment in old age homes since the P-value was 0.547 Level. Both male inmates and female inmates were equally satisfied (nearly 80%) and equally dissatisfied (nearly 20%) with the living environment in their old age homes.
b) Majority of all age group of inmates satisfied with their living environments. It was found that there was no correlation between the age group of inmates (P = 0.558) with their living environment.
c) Based on the type of old age homes there was a significant difference with regard to the living environment of inmates [P = 0.020]. Particularly, Free home inmates were more (83%) satisfied with their living environment than paid home inmates (76%). Majority of inmates in paid homes always find fault with their management and try to move from one old age home to another old age home.

Table 7.15 Association between satisfactions of living environments with selected socio-demographic factors (Gender, Age, Type of home, Sources of income and Type of room).

Socio-demographic factors	Are you satisfied with the living environment in old age home?		N=710 Total	P Value
	Satisfied	Dissatisfied		
a) Gender				0.547
Male	142 (78.0%)	40 (22.0%)	182 (100%)	
Female	423 (80.1%)	105 (19.9%)	528 (100%)	
b) Age				0.558
60-69	106 (83.5%)	21 (16.5%)	127 (100%)	
70-79	235 (76.5%)	72 (23.5%)	307 (100%)	
80-89	203 (83.2%)	41 (16.8%)	244 (100%)	
90-99	21 (65.6%)	11 (34.4%)	32 (100%)	
c) Type of home				0.020*
Free	315 (82.9%)	65 (17.1%)	380 (100%)	
Paid	208 (76.2%)	65 (23.8%)	273 (100%)	
Free-cum-Paid	42 (73.7%)	15 (26.3%)	57 (100%)	
d) Sources of income				0.110
Son	86(76.8%)	26(23.2%)	112 (100%)	
Daughter	34 (73.9%)	12 (26.1%)	46 (100%)	
Relatives	66 (76.7%)	20 (23.3%)	86 (100%)	
Pension	56 (80.0%)	14 (20.0%)	70 (100%)	
Property	7 (70.0%)	3 (30.0%)	10 (100%)	
None	316 (81.9%)	70 (18.1%)	386 (100%)	
e) Types of room				0.035*
Dormitory	282 (82.2%)	61 (17.8%)	343 (100%)	
Single occupied	32 (86.5%)	5 (13.5%)	37 (100%)	
Twin sharing	196 (76.9%)	59 (23.1%)	255 (100%)	
Triple sharing	55 (73.3%)	20 (26.7%)	75 (100%)	

Note : * denotes significant at 5% level

d) Table 7.15 also shows the association between the satisfaction of living environment with sources of income of inmates. There was no significant difference [P = 0.110] between living environment with regard to the sources of income since the P-value was > 0.05 level.

e) It was observed that there was a correlation between [P = 0.035] types of room in old age home with regard to the satisfaction of the living environment. Out of 710 inmates, the majority of them (345) live in the dormitories and only 37 inmates live alone in one room.

Table 7.16 Association between the satisfaction of living environment with selected socio-demographic factors [Number of roommates, Length of stay in the home, Type of food, Outside visit of inmates, Exercise facilities in homes and Medical facilities.]

Socio-demographic factors	Are you satisfied with the living environment in old age home?		N=710 Total	P Value
	Satisfied	Dissatisfied		
f) Roommates				
1 to 3	282 (76.8%)	85 (23.2%)	367 (100%)	0.005**
4 to 6	197 (79.1%)	52 (20.9%)	249 (100%)	
Above 6	86 (91.5%)	8 (8.5%)	94 (100%)	
g) Length of stay				0.396
Less than 1 year	103 (75.2%)	34 (24.8%)	137 (100%)	
1 to 5 years	285 (82.1%)	62 (17.9%)	347 (100%)	
5 to 10 years	141 (75.8%)	45 (24.2%)	186 (100%)	
Above 10 years	36 (90.0%)	4 (10.0%)	40 (100%)	
h) Type of Food				0.389
Vegetarian	425 (80.3%)	104 (19.7%)	529 (100%)	
Non vegetarian	140 (77.3%)	41 (22.7%)	181 (100%)	
i) Outside visit of inmates				0.029*
Allowed	371 (82.1%)	81 (17.9%)	452 (100%)	
Not allowed	194 (75.2%)	64 (24.8%)	258 (100%)	
j) Exercise facilities				0.015*
Available	456 (82.0%)	100 (18.0%)	556 (100%)	
Not available	109 (70.8%)	45 (29.2%)	154 (100%)	
k) Medical facilities				0.002**
Available	456 (82.0%)	100 (18.0%)	556 (100%)	
Not available	109 (70.8%)	45 (29.2%)	154 (100%)	

Note : ** denotes significant at 1% level
* denotes significant at 5% level

Table 7.16 reveals the association of satisfaction of living environment with selected socio-demographic factors of f) Number of roommates, g) Length of stay in home, h) Type of food, i) Outside visit of inmates j) Exercise facilities in homes and k) Medical facilities.

f) Since the P-value was very small [P = 0.005] in the association between the level of satisfaction of the living environment and number of roommates was statistically significant.

g) Out of 710 inmates, the majority of them (347) had been staying 1 to 5 years in old age home. Results revealed that there was no correlation between length of stay in old age home with regard to satisfaction of living environment since the P-value was larger than 0.05 level of significance [P = 0.396].

h) It was also observed [Table – 7.16] that there was no significant difference between the type of food (Vegetarian / Non-Vegetarian) with regard to satisfaction of living environment since the P-value was 0.389 level.

i) Out of 710 inmates, 258 inmates were not allowed by their old age home to go for an outside visit. It was found that there was a significant difference between the outside visit of inmates with regard to satisfaction of living environment since the P-value was < 0.05 level [P = 0.029].

j) Based on above findings, It was found that there was a significant difference between the availability of exercise facilities in old age homes with regard to satisfaction of living environment of inmates since the P-value was < 0.05 level [P = 0.015].

k) It was observed that there was a significant correlation between medical facilities with regard to satisfaction of living environment since the P-value was < 0.05 level of significance [P = 0.002].

Table 7.17 shows the association of living environment with selected socio-demographic factors of l) Socialize with others, m) Family support, n) Safety of inmates, o) Transport facilities p) Access to information and q) Useful activities.

l) It was observed that there was a significant difference between living environments with regard to inmates' socialization with others since the P-value was < 0.001 level of significance. Majority of inmates (371) moderately socialized with other inmates in their homes.

m) Table 7.17 also shows the result of family support with regard to the satisfaction of the living environment. There was a strong relation between them since the P-value was < 0.001 level of significance. Out of 710 inmates, the majority of inmates (483) were dissatisfied by the lack of family support.

n) Majority of inmates (649) were satisfied by their safety in old age homes. It was noted that there was a strong correlation between living environments with the safety of inmates since the P-value was < 0.001 level of significance.

o) It was also observed that there was no significant difference between the transport facility with the living environment [P = 0.253] of inmates.

p) Out of 710 inmates, 530 inmates were satisfied with the availability of information, There was a significant correlation with access to information in homes with regard to satisfaction of living environment of inmates since the P-value was < 0.05 level of significance [P =0.021].

q) There was a highly significant difference between useful activities of inmates with regard to the living environment of homes since the P-value was <0.001 level.

Table 7.17 Associations between satisfaction of living environment with selected socio-demographic factors [Socialize with others, Family support, Safety of inmates, Transport facilities, Access to information and Useful activities]

Socio-demographic factors	Are you satisfied with the living environment in old age home?		N=710 Total	P value
	Satisfied	Dissatisfied		
l) Socialize with others				0.000**
Not at all	21 (61.8%)	13 (38.2%)	34 (100%)	
Moderately	282 (76.0%)	89 (24.0%)	371 (100%)	
Completely	262 (85.9%)	43 (14.1%)	305 (100%)	
m) Family support				0.000**
Satisfied	139 (61.2%)	88 (38.8%)	227 (100%)	
Dissatisfied	426 (88.2%)	57 (11.8%)	483 (100%)	
n) Safety of inmates				0.000**
Satisfied	504 (77.7%)	145 (22.3%)	649 (100%)	
Dissatisfied	61 (100%)	0 (0.0%)	61 (100%)	
o) Transport facility				0.253
Satisfied	326 (81.1%)	76 (18.9%)	402 (100%)	
Dissatisfied	239 (77.6%)	69 (22.4%)	308 (100%)	
p)Availability of information				0.021*
Satisfied	411 (77.5%)	119 (22.5%)	530 (100%)	
Dissatisfied	154 (85.6%)	26 (14.4%)	180 (100%)	
q) Useful activities				0.000**
Not at all	193 (86.9%)	29 (13.1%)	222 (100%)	
Moderately	339 (78.5%)	93 (21.5%)	432 (100%)	
Completely	33 (58.9%)	23 (41.1%)	56 (100%)	

Note : ** denotes significant at 1% level

* denotes significant at 5% level

Chapter VIII

Socio-Economic Support to the inmates

In this chapter, Socio-Economic supports to the inmates have been analysed. It consists of three sections. They are;

Section I - Socio-Economic support of the family members,

Section II - Socio-Economic support of the old age home and

Section III - Socio-Economic support of the Government.

8.1 Section 1: Socio-Economic support of the family members

Table 8.1 Frequency of inmates' family visit to the old age home

How often do your family members visit you in a year?		Gender		Total
		Male	Female	
More than twice a year	N	0	3	3
	%	0.0	0.6	0.4
Twice a year	N	0	7	7
	%	0.0	1.4	1.0
Once a year	N	13	26	39
	%	7.1	4.9	5.5
Seldom	N	61	184	245
	%	33.5	34.8	34.5
Never	N	23	66	89
	%	12.6	12.5	12.5
Not applicable	N	85	242	327
	%	46.7	45.8	46.1
Total	N	182	528	710
	%	100.0	100.0	100.0

This table (8.1) shows how often the inmates' family members visited the old age home. 0.4% of inmates' family members visited the home more than twice in a year. 1% of inmates' family members visited the home twice a year. 5.5% of inmates (39) visited by their family members once a year. 34.5% of inmates (245) stated that they rarely visited and 12.5% of inmates (89) never visited by their family members. 327 inmates (46.1%) stated that there was no family member to visit them.

Table 8.2 Frequency of family's talk on the phone with the inmates

How often does your family member speak on the telephone with you?	Gender		Total
	Male	Female	
Once a week	0 0.0%	0 0.0%	0 0.0%
Few times a year	17 9.3%	35 6.6%	52 7.3%
Seldom	60 33.0%	231 43.8%	291 41.0%
Never	11 6.0%	29 5.5%	40 5.6%
Not applicable	94 51.7%	233 44.1%	327 46.1%
Total	182 100.0%	528 100.0%	710 100.0%

The above table (8.2) shows how often the inmates' family members speak on the phone. Out of 710 inmates, 40 inmates' family members (5.6%) had never spoken with the inmates. 291 inmates' family members (41.0%) had rarely spoken with the inmates. 7.3% of inmates' family members speak a few times a year. But no family member (0.0%) of inmates had spoken weekly once. 46.1% of inmates (327) not applicable to this question because they did not have family members at present.

Table 8.3 Awareness of inmates about elder abuse

Elder abuse			Age group of inmates				Total
			60-69	70-79	80-89	90-99	
Are you aware of elder abuse?	Yes	N	74	189	155	20	438
		%	58.3	61.6	63.5	62.5	61.7
	No	N	53	118	89	12	272
		%	41.7	38.4	36.5	37.5	38.3
Total		N	127	307	244	32	710
		%	100.0	100.0	100.0	100.0	100.0

The above table (8.3) reveals the level of awareness of inmates about elder abuse. Based on the age group of inmates, 61.7% of inmates (438) were aware of elder abuse. Among them, 60 to 69 years old inmates were 74, 70 to 79 years old inmates

were 189, 80 to 89 years old inmates were 155 and 90 to 99 years old inmates were 20. Out of 710 inmates, 272 inmates (38.3%) were unaware of elder abuse.

Table 8.4 Abused inmates based on their age group

Elder abuse			Age group of inmates				Total
			60-69	70-79	80-89	90-99	
Abused by family members	Yes	N	62	169	145	21	397
		%	48.8	55.0	59.4	65.6	55.9
	No	N	65	138	99	11	313
		%	51.2	45.0	40.6	34.4	44.1
Total		N	127	307	244	32	710
		%	100.0	100.0	100.0	100.0	100.0
Abused by non-relatives	Yes	N	11	26	8	2	47
		%	8.7	8.5	3.3	6.2	6.6
	No	N	116	281	236	30	663
		%	91.3	91.5	96.7	93.8	93.4
Total		N	127	307	244	32	710
		%	100.0	100.0	100.0	100.0	100.0
Abused by staff members	Yes	N	1	9	2	1	13
		%	0.8	2.9	0.8	3.1	1.8
	No	N	126	298	242	31	697
		%	99.2	97.1	99.2	96.9	98.2
Total		N	127	307	244	32	710
		%	100.0	100.0	100.0	100.0	100.0

The above table (8.4) shows the distribution of abused inmates based on their age group. 55.9% of inmates (397) were abused by their family members. 6.6% of inmates (47) were abused by non-relatives and 1.8% of inmates (13) abused by staff members of the old age homes.

At the district level, the highest percentage of inmates (90%) was aware of elder abuse in Chennai. Majority of inmates (80%) were also abused by family members in Chennai. The highest percentage of inmates (39%) was abused by non-relatives in Kancheepuram district. Majority of inmates stated that they were abused by staff members in Vellore district. But in the perspectives of staff members, strictly they follow the rules and do their services.

Table 8.5 District wise distribution of abused inmates

District	Old age home (OAH)	Elder abuse				Total Inmates N
		Aware of elder abuse	Abused by family members	Abused by non-relatives	Abused by staff members	
Chennai	OAH -1	89%	60%	10%	0%	84
	OAH -2	59%	79%	0%	0%	81
	OAH -3	90%	80%	0%	0%	40
	OAH -4	50%	47%	0%	10%	30
	OAH -5	48%	41%	15%	11%	27
Kanchee -puram	OAH -6	51%	51%	37%	10%	49
	OAH -7	40%	47%	39%	13%	15
	OAH -8	63%	64%	13%	0%	38
	OAH -9	59%	60%	9%	0%	32
	OAH -10	58%	57%	8%	0%	26
Vellore	OAH -11	53%	31%	16%	10%	38
	OAH -12	54%	33%	12%	16%	24
	OAH -13	57%	38%	14%	10%	21
	OAH -14	53%	34%	13%	13%	15
	OAH -15	56%	31%	17%	6%	36
Thiru -vallur	OAH -16	60%	58%	23%	3%	62
	OAH -17	42%	58%	16%	0%	12
	OAH -18	50%	67%	17%	0%	6
	OAH -19	61%	60%	21%	3%	66
	OAH -20	50%	49%	0%	15%	8
Total		438	397	47	13	710
		61.7%	55.9%	6.6%	1.8%	

Table 8.6 Distribution of abused inmates (Psychological abuse & Economic abuse)

Types of elder abuse		Gender		Total
		Male	Female	
Psychological abuse	Yes	82 45.1%	209 39.6%	291 41.0%
	No	100 54.9%	319 60.4%	419 59.0%
Total		182 100.0%	528 100.0%	710 100.0%
Economic abuse	Yes	38 20.9%	109 20.6%	147 20.7%
	No	144 79.1%	419 79.4%	563 79.3%
Total		182 100.0%	528 100.0%	710 100.0%

Table 8.6 explains how inmates were abused by the people. Two types of elder abuse have been analysed. 45.1% of male inmates (82) and 39.6% of female inmates (209) were psychologically abused. 20.9% of male inmates (38) and 20.6% of female inmates (109) were economically abused. Out of 710 inmates, 291 inmates (41.0%) were psychologically abused and 147 inmates (20.7%) were economically abused.

Table 8.7 Distribution of abused inmates (Physical abuse & Verbal abuse)

Types of elder abuse		Gender		Total
		Male	Female	
Physical abuse	Yes	16 8.8%	49 9.3%	65 9.2%
	No	166 91.2%	479 90.7%	645 90.8%
Total		182 100.0%	528 100.0%	710 100.0%
Verbal abuse	Yes	67 36.8%	171 32.4%	238 33.5%
	No	115 63.2%	357 67.6%	472 66.5%
Total		182 100.0%	528 100.0%	710 100.0%

The above table (8.7) explains how inmates were abused by the people. Two types of elder abuse have been analysed. 8.8% of male inmates (16) and 9.3% of female inmates (49) were physically abused. 36.8% of male inmates (67) and 32.4% of female inmates (171) were verbally abused. Out of 710 inmates, 65 inmates (9.2%) were physically abused and 238 inmates (33.5%) were verbally abused.

Table 8.8 reveals the district wise distribution of abused inmates on various types. Out of 20 old age homes, the highest percentage of psychological abuse (80%), economic abuse (37%) and physical abuse (18%) had taken place in Chennai. In verbal abuse, Kancheepuram had secured the highest percentage (63%). 21% of inmates (147) were economically abused by their family members.

Table 8.8 District wise distribution of types of elder abuses

District	Old Age Home (OAH)	Types of Elder abuse				Total Inmates N
		Psychological abuse	Economic abuse	Physical abuse	Verbal abuse	
Chennai	OAH -1	80%	20%	0%	33%	84
	OAH -2	20%	21%	18%	40%	81
	OAH -3	20%	30%	10%	20%	40
	OAH -4	43%	37%	13%	33%	30
	OAH -5	37%	26%	11%	48%	27
Kanchee -puram	OAH -6	59%	20%	10%	41%	49
	OAH -7	60%	20%	10%	40%	15
	OAH -8	61%	21%	0%	58%	38
	OAH -9	59%	19%	0%	63%	32
	OAH -10	62%	19%	0%	62%	26
Vellore	OAH -11	13%	16%	0%	13%	38
	OAH -12	17%	13%	0%	17%	24
	OAH -13	14%	14%	0%	14%	21
	OAH -14	13%	20%	0%	13%	15
	OAH -15	17%	14%	0%	17%	36
Thiru -vallur	OAH -16	40%	19%	13%	26%	62
	OAH -17	33%	25%	8%	25%	12
	OAH -18	50%	17%	17%	17%	6
	OAH -19	39%	21%	12%	26%	66
	OAH -20	38%	13%	13%	13%	8
Total		291	147	65	238	710
		41.0%	20.7%	9.2%	33.5%	100 %

Table 8.9 Inmates' preference regarding living arrangements

Which kind of Living arrangement do you prefer?	Gender		Total
	Male	Female	
Live alone	0 0.0%	0 0.0%	0 0.0%
Live with spouse	0 0.0%	0 0.0%	0 0.0%
Live with children	2 1.1%	6 1.1%	8 1.1%
Live in a nuclear family	0 0.0%	0 0.0%	0 0.0%
Live in extended family	38 20.9%	144 27.3%	182 25.6%
Live in old age home	142 78.0%	378 71.6%	520 73.2%
Total	182 100.0%	528 100.0%	710 100.0%

Table 8.9 shows the distribution of inmates by their willingness about living arrangements. 78% of male inmates (142) and 71.6% of female inmates (378) wanted to live in old age home. Because they said, 'We get everything in old age home like food, shelter, cloth, entertainment, interaction, friends and etc.' Out of 710 inmates, no one wanted to live alone, live with spouse alone or live in a nuclear family. But 20.9% of male inmates (38) and 27.3% of female inmates (144) wanted to live in an extended family. No major differences were noted on this aspect between the elderly male and female inmates.

8.2 Section 2: Socio-economic support of old age home

Table 8.10 Distribution of inmates by their outside visit

How often do you go out of the old age home?	Gender		Total
	Male	Female	
Often	2 1.1%	6 1.1%	8 1.1%
Weekly once	11 6.0%	27 5.1%	38 5.4%
Monthly once	15 8.2%	35 6.6%	50 7.0%
Rarely	108 59.3%	337 63.8%	445 62.7%
Never	43 23.6%	116 22.0%	159 22.4%
Not applicable	3 1.6%	7 1.3%	10 1.4%
Total	182 100.0%	528 100.0%	710 100.0%

The above table (8.10) explains the outside visit of inmates in old age home. Out of 710 inmates, 445 inmates (62.7%) rarely go outside of old age home. 159 inmates (22.4%) had never gone outside of their home. 50 inmates (7.0%) were monthly once going outside, 38 inmates were weekly once going outside and 8 inmates (1.1%) were often going outside of the old age home. But 10 inmates (1.4%) could not go outside because of their locomotive disability.

Table 8.11 describes the distribution of inmates by the availability of caretakers in old age home. Out of 710 inmates, only 182 inmates (25.6%) had got

primary caretaker, among them 34.6% were male inmates and 22.5% were female inmates. In paid homes, the inmates had to pay separate money for caretakers.

Table 8.11 Distribution of inmates by the availability of caretakers in old age home

Do you have a primary caretaker to help you?	Gender		Total
	Male	Female	
Yes	63 34.6%	119 22.5%	182 25.6%
No	119 65.4%	409 77.5%	528 74.4%
Total	182 100.0%	528 100.0%	710 100.0%

Table 8.12 Availability of primary caretaker in old age homes

How often the primary caretaker is helpful?	Gender		Total
	Male	Female	
Full time	34 18.7%	48 9.1%	82 11.5%
Only night time	2 1.1%	10 1.9%	12 1.7%
Only day time	10 5.5%	20 3.8%	30 4.2%
Only when I call	17 9.3%	41 7.8%	58 8.2%
Not applicable	119 65.4%	409 77.5%	528 74.4%
Total	182 100.0%	528 100.0%	710 100.0%

Table 8.12 shows the availability of primary caretaker in old age homes. 11.5% of inmates (82) had got full-time primary caretakers. 1.7% of inmates (12) had got primary caretakers only in the night time and 4.2% of inmates (30) had got only in the day time. 8.2 % of inmates had got primary caretakers only when they called. Particularly in paid homes, primary caretakers were available. 74.4% of inmates were not applicable.

Table 8.13 explains the problems of inmates in old age home. The highest percentage of inmates in Thiruvallur district was facing the problem of insufficient money. Inmates from Kancheepuram district highlighted the problem of poor housing

and poor medical care. The highest percentage of inmates from Vellore highlighted the problem of lack of companionship. All the above mentioned problems were less in Chennai district.

Table 8.13 Distribution of inmates by their old age homes based on their problems

District	Old age home (OAH)	Problems of inmates				Total Inmates N
		Insufficient money	Poor housing	Poor medical care	Lack of companion-ship	
Chennai	OAH -1	69%	1%	1%	0%	84
	OAH -2	80%	0%	1%	0%	81
	OAH -3	80%	10%	87%	10%	40
	OAH -4	81%	20%	40%	0%	30
	OAH -5	89%	15%	48%	1%	27
Kanchee -puram	OAH -6	99%	0%	1%	1%	49
	OAH -7	98%	90%	97%	2%	15
	OAH -8	82%	42%	61%	18%	38
	OAH -9	78%	38%	59%	22%	32
	OAH -10	81%	39%	62%	19%	26
Vellore	OAH -11	87%	16%	58%	26%	38
	OAH -12	83%	13%	58%	33%	24
	OAH -13	86%	14%	62%	29%	21
	OAH -14	87%	20%	60%	26%	15
	OAH -15	83%	14%	61%	33%	36
Thiru -vallur	OAH -16	99%	13%	24%	12%	62
	OAH -17	99%	8%	25%	8%	12
	OAH -18	98%	17%	33%	17%	6
	OAH -19	46%	12%	24%	12%	66
	OAH -20	63%	13%	38%	13%	8
Total		573	106	253	82	710
		81%	15%	36%	12%	100 %

Table 8.14 illustrates the problems of inmates in old age homes. 80.7% of inmates (573) stated that their main problem was insufficient money. 14.9% of inmates (106) highlighted poor housing. 35.6% of inmates (253) explained their problem of poor medical care. Only 11.5% of inmates (82) stated the problem of lack of companionship.

Table 8.14 Problem of inmates

Problems of inmates		Gender				Total	
		Male		Female			
		N	%	N	%	N	%
Insufficient money	Yes	145	79.7	428	81.1	573	80.7
	No	37	20.3	100	18.9	137	19.3
Total		182	100.0	528	100.0	710	100.0
Poor housing	Yes	31	17.0	75	14.2	106	14.9
	No	151	83.0	453	85.8	604	85.1
Total		182	100.0	528	100.0	710	100.0
Poor medical care	Yes	66	36.3	187	35.4	253	35.6
	No	116	63.7	341	64.6	457	64.4
Total		182	100.0	528	100.0	710	100.0
Lack of companion -ship	Yes	22	12.1	60	11.4	82	11.5
	No	160	87.9	468	88.6	628	88.5
Total		182	100.0	528	100.0	710	100.0

Table 8.15 Psychological problems of inmates

Problems of inmates		Gender				Total	
		Male		Female			
		N	%	N	%	N	%
Being dependent	Yes	79	43.4	212	40.2	291	41.0
	No	103	56.6	316	59.8	419	59.0
Total		182	100.0	528	100.0	710	100.0
Disappointment	Yes	58	31.9	122	23.1	180	25.4
	No	124	68.1	406	76.9	530	74.6
Total		182	100.0	528	100.0	710	100.0
Loss of confidence	Yes	37	20.3	85	16.1	122	17.2
	No	145	79.7	443	83.9	588	82.8
Total		182	100.0	528	100.0	710	100.0
Fear of crime	Yes	0	0.0	0	0.0	0	0.0
	No	182	100	528	100	710	100.0
Total		182	100.0	528	100.0	710	100.0

Table 8.15 highlights the psychological problems of inmates. 43.4% of male inmates and 40.2% of female inmates stated that they were being dependent on others. 25.4% of inmates (180) highlighted the problem of their disappointment. 17.2% of inmates (122) stated that they lost confidence in their health status. Out of 710 inmates, no one (0.0%) in the old age home feared about crime. They feel safe in their old age home.

Table 8.16 Distribution of inmates by their frequency of prayer

How many times do you pray?	Gender		Total
	Male	Female	
Often	77 42.3%	178 33.7%	255 35.9%
Regularly	94 51.6%	320 60.6%	414 58.3%
Sometimes	8 4.4%	30 5.7%	38 5.4%
No	3 1.6%	0 0.0%	3 0.4%
Total	182 100.0%	528 100.0%	710 100.0%

Table 8.16 explains the interest of prayer of inmates in old age home. 42.3% of male inmates (77) and 33.7% of female inmates (178) often worshipped their god. 58.3% of inmates regularly prayed. 5.4% of inmates (38) sometimes prayed and 0.4% of inmates (3) did not pray. Out of 710 inmates, the majority of inmates (414) prayed (58.3%) regularly.

Table 8.17 Distribution of inmates and availability of health support products

Health support products		Type of purchase						Total	
		Through home		I purchase		I don't use			
		N	%	N	%	N	%	N	%
Stick	Male	25	13.7	17	9.3	140	76.9	182	100
	Female	75	14.2	28	5.3	425	80.5	528	100
Total		100	14.1	45	6.3	565	79.6	710	100
Crutches	Male	2	1.1	1	0.5	179	98.4	182	100
	Female	7	1.3	2	0.4	519	98.3	528	100
Total		9	1.3	3	0.4	698	98.3	710	100

The above table (8.17) explains the type of purchase of health-supportive products. Majority of free old age homes provide health-supportive products to the inmates in free of cost. But in paid homes, inmates had to purchase these products. Out of 710 inmates, nearly 80% of inmates (565) were not using the stick. 14.1% of inmates (100) had got the stick through old age home and 6.3% of inmates (45) had purchased themselves. 98.3% of inmates (698) were not using the crutches. 1.3% of inmates (9) had got crutches through the home and 0.4% of inmates (3) purchased themselves.

Table 8.18 Availability of wheelchair and walker

Health supportive products		Type of purchase						Total	
		Through home		I purchase		I don't use			
		N	%	N	%	N	%	N	%
Wheel -chair	Male	13	7.1	10	5.5	159	87.4	182	100
	Female	35	6.6	16	3.0	477	90.3	528	100
Total		48	6.8	26	3.7	636	89.6	710	100
Walker	Male	16	8.8	13	7.1	153	84.1	182	100
	Female	37	7.0	21	4.0	470	89.0	528	100
Total		53	7.5	34	4.8	623	87.7	710	100

The above table (8.18) highlights the distribution of inmates by the availability of health supportive products. Out of 710 inmates, nearly 90% of inmates (636) were not using the Wheelchair. 6.8% of inmates (48) had got Wheelchair through the home and 3.7% of inmates (26) had purchased themselves in the paid home. 87.7% of inmates (623) were not using the Walker. 7.5% of inmates (53) had got Walker through the home and 4.8% of inmates (34) had purchased themselves. Out of 710 inmates, no one had used the leg brace, back brace and artificial limbs.

Table 8.19 describes the availability of health-supportive products to the inmates (Hearing aid, Spectacles and Denture). Out of 710 inmates, nearly 90% of inmates (637) were not using the hearing aid. 4.5% of inmates (32) had got hearing aid through the home and 5.8% of inmates (41) had purchased themselves. 59.2% of inmates (420) were not using the spectacles. 21.0% of inmates (149) had got spectacles through the home and 19.9% of inmates (141) had purchased themselves. 87.6% of

inmates (622) were not using the denture. 4.1% of inmates (29) had got denture through the home and 8.3% of inmates (59) had purchased themselves.

Table 8.19 Distribution of inmates and the availability of health-supportive products

Health supportive products		Type of purchase						Total	
		Through home		I purchase		I don't use			
		N	%	N	%	N	%	N	%
Hearing aid	Male	5	2.7	14	7.7	163	89.6	182	100
	Female	27	5.1	27	5.1	474	89.8	528	100
Total		32	4.5	41	5.8	637	89.7	710	100
Spectacles	Male	30	16.5	45	24.7	107	58.8	182	100
	Female	119	22.5	96	18.2	313	59.3	528	100
Total		149	21.0	141	19.9	420	59.2	710	100
Denture	Male	5	2.7	22	12.1	155	85.2	182	100
	Female	24	4.5	37	7.0	467	88.4	528	100
Total		29	4.1	59	8.3	622	87.6	710	100

8.3 Section III – Socio-economic support of the Government

Table 8.20 reveals the awareness of inmates about social security schemes. a) 3.3% of male inmates (6) and 0.9% of female inmates (5) were aware of Indira Gandhi National Old Age Pension Scheme. Out of 710 inmates, only 11 inmates were aware of this scheme.

b) 3.3% of male inmates (6) and 0.8% of female inmates (4) were aware of the Indira Gandhi National Disability Pension Scheme. Out of 710 inmates, only 10 inmates were aware of this scheme.

c) 2.2% of male inmates (4) and 0.4% of female inmates (2) were aware of Indira Gandhi National Widow Pension Scheme. Out of 710 inmates, only 6 inmates were aware of this scheme.

d) 1.6% of male inmates (3) and 0.2% of female inmates (1) were aware of destitute differently-abled Scheme. Out of 710 inmates, only 4 inmates were aware of this scheme.

Table 8.20 Inmates' awareness about social security schemes of the government (IGNOAPS, IGNDPS, IGNWPS and DDPS)

Do you aware of the following social security schemes?			Gender		Total
			Male	Female	
a) Indira Gandhi National Old Age Pension Scheme	Yes	N	6	5	11
		%	3.3	0.9	1.5
	No	N	176	523	699
		%	96.7	99.1	98.5
Total		N	182	528	710
		%	100.0	100.0	100.0
b) Indira Gandhi National Disability Pension Scheme	Yes	N	6	4	10
		%	3.3	0.8	1.4
	No	N	176	524	700
		%	96.7	99.2	98.6
Total		N	182	528	710
		%	100.0	100.0	100.0
c) Indira Gandhi National Widow Pension Scheme	Yes	N	4	2	6
		%	2.2	0.4	0.8
	No	N	178	526	704
		%	97.8	99.6	99.2
Total		N	182	528	710
		%	100.0	100.0	100.0
d) Destitute differently-abled Pension scheme	Yes	N	3	1	4
		%	1.6	0.2	0.6
	No	N	179	527	706
		%	98.4	99.8	99.4
Total		N	182	528	710
		%	100.0	100.0	100.0

Table 8.21 reveals the awareness of inmates about social security schemes.

e) 3.3% of male inmates (6) and 0.6% of female inmates (3) were aware of the Destitute widow's Pension Scheme. Out of 710 inmates, only 9 inmates were aware of this scheme.

f) 1.1% of male inmates (2) were aware of the Destitute agricultural labourers Pension Scheme. Out of 710 inmates, only 2 inmates were aware of this scheme. Female inmates were not aware of this scheme.

Table 8.21 Inmates' awareness about social security schemes of the government (DWPS and DALPS)

Do you aware of the following social security schemes?			Gender		Total
			Male	Female	
e) Destitute widows Pension Scheme	Yes	N	6	3	9
		%	3.3	0.6	1.3
	No	N	176	525	701
		%	96.7	99.4	98.7
Total		N	182	528	710
		%	100.0	100.0	100.0
f) Destitute agricultural labourers pension scheme	Yes	N	2	0	2
		%	1.1	0.0	0.3
	No	N	180	528	708
		%	98.9	100	99.7
Total		N	182	528	710
		%	100.0	100.0	100.0

Table 8.22 Inmates' awareness about social security schemes of the government (DPS and PUW)

Do you aware of the following social security schemes?			Gender		Total
			Male	Female	
g) Deserted wives pension scheme	Yes	N	4	0	4
		%	2.2	0.0	0.6
	No	N	178	528	706
		%	97.8	100	99.4
Total		N	182	528	710
		%	100.0	100.0	100.0
h) Pension to unmarried, poor women	Yes	N	6	2	8
		%	3.3	0.4	1.1
	No	N	176	526	702
		%	96.7	99.6	98.9
Total		N	182	528	710
		%	100.0	100.0	100.0

The above table (8.22) reveals the awareness of inmates about social security schemes. **g)** 2.2% of male inmates (4) were aware of the Deserted wives Pension Scheme. Out of 710 inmates, only 4 inmates were aware of this scheme. Female inmates were not aware of this scheme. **h)** 3.3% of male inmates (6) and 0.4% of female inmates (2) were aware of Pension to unmarried, poor women Scheme. Out of 710 inmates, only 8 inmates were aware of this scheme.

Table 8.23 Inmates' awareness about social security schemes of the government (CMCHISTN and OAP)

Do you aware of the following social security schemes?			Gender		Total
			Male	Female	
i) Chief Minister's Health Insurance Scheme	Yes	N	28	75	103
		%	15.4	14.2	14.5
	No	N	154	453	607
		%	84.6	85.8	85.5
Total		N	182	528	710
		%	100.0	100.0	100.0
j) Tamilnadu Government Old Age Pension Scheme	Yes	N	151	436	587
		%	83.0	82.6	82.7
	No	N	31	92	123
		%	17.0	17.4	17.3
Total		N	182	528	710
		%	100.0	100.0	100.0

The above table (8.23) reveals the awareness of inmates about social security schemes. **i)** 15.4% of male inmates (28) and 14.2% of female inmates (75) were aware of the Chief Minister's health insurance scheme in Tamilnadu. Out of 710 inmates, 103 inmates were aware of this scheme. **j)** 83.0% of male inmates (151) and 82.6% of female inmates (436) were aware of the Tamilnadu Government old age pension scheme. Out of 710 inmates, 587 inmates were aware of this scheme. But only 11 inmates were receiving the pension under this scheme.

Chart 8.1 Inmates awareness about social security schemes in Tamilnadu

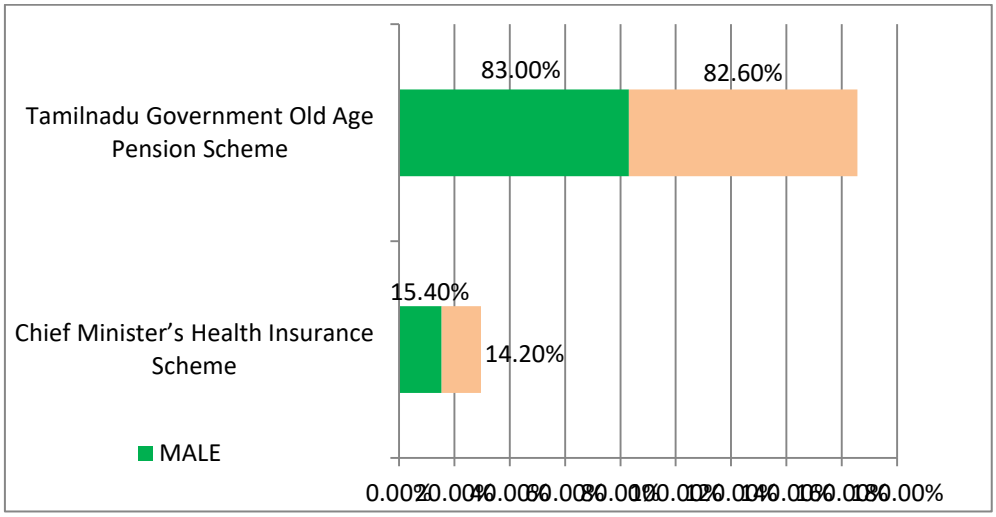


Chart 8.2 Inmates' awareness about social security schemes

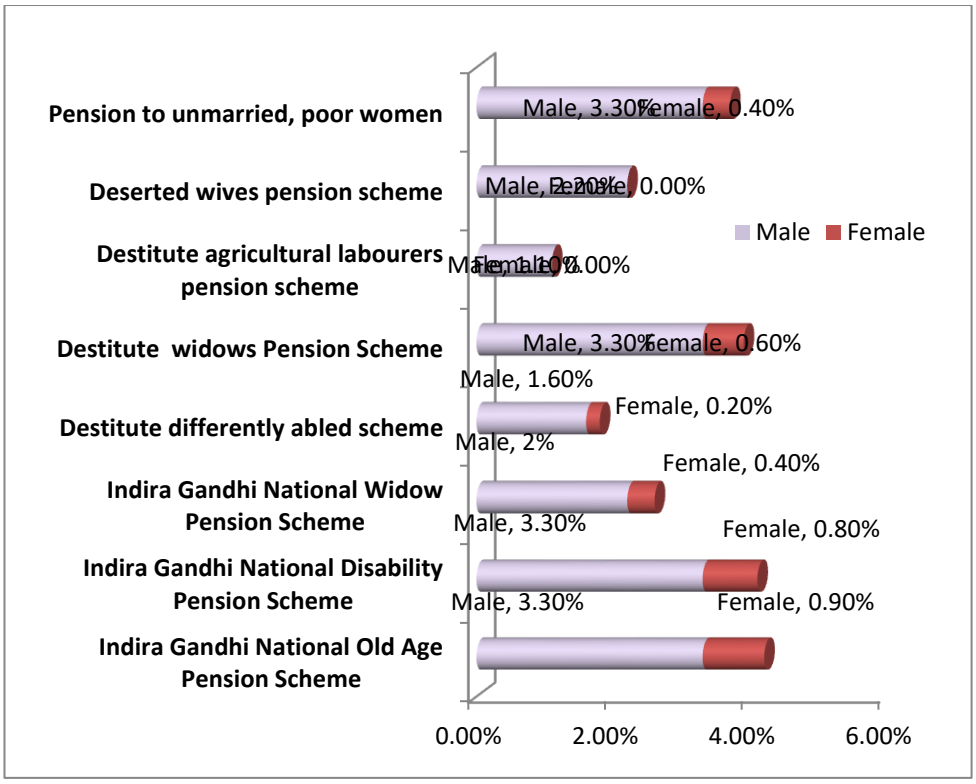


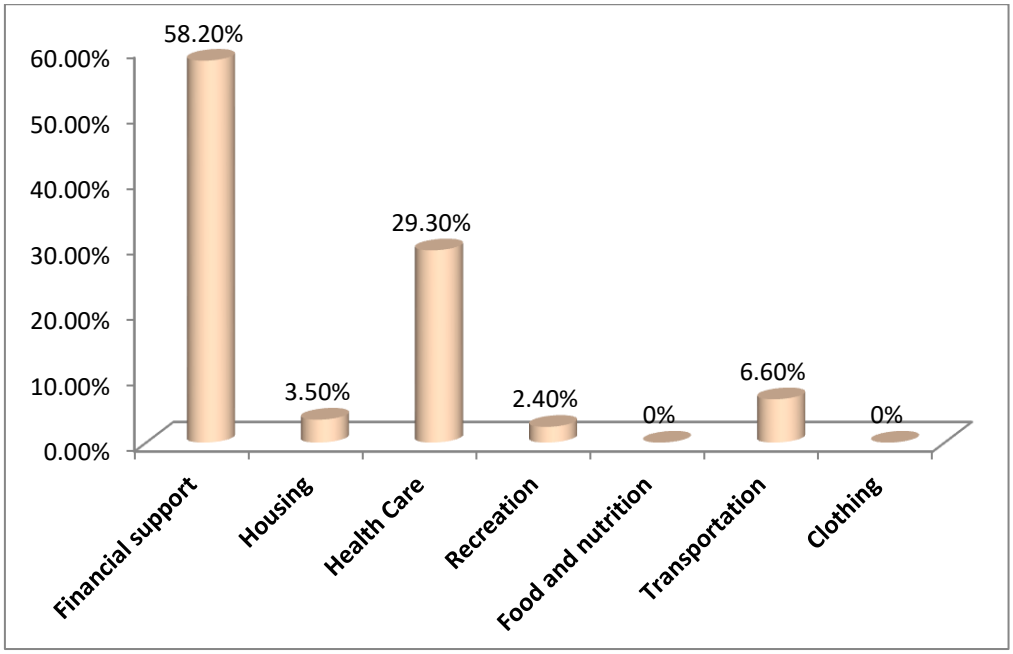
Table 8.24 Distribution of inmates by their expectation from government

What kind of support do you expect from the government?	Gender		Total
	Male	Female	
Financial support	104 57.1%	309 58.5%	413 58.2%
Housing	5 2.7%	20 3.8%	25 3.5%
Health Care	60 33.0%	148 28.0%	208 29.3%
Recreation	4 2.2%	13 2.5%	17 2.4%
Food and nutrition	0 0.0%	0 0.0%	0 0.0%
Transportation	9 4.9%	38 7.2%	47 6.6%
Clothing	0 0.0%	0 0.0%	0 0.0%
Total	182 100.0%	528 100.0%	710 100.0%

Table 8.24 shows inmates' expectation about the support of the government. Majority of inmates (58.2%) expected financial support from the

government. Out of 710 inmates, 25 inmates (3.5%) expected housing support, 208 inmates (29.3%) expected health care support, 17 inmates (2.4%) expected recreational activities and 47 inmates (6.6%) expected transport facilities from the government. No one expected clothing, food and nutritional support from the government.

Chart 8.3 Inmates expectation from the Government



8.4 Results of ANOVA with socio-economic support to inmates

Table 8.25 reveals the association of family support with socio-demographic factors of Type of home, Age, Sources of income and Outside visit of inmates.

a) The result revealed that there was a significant difference between types of homes with family support of inmates since the P-value was < 0.001 level of significance. The paid home inmates satisfied (45.4%) more with the support of their family members than free home (22.6%) and free-cum-paid (29.8%) inmates.

b) It was observed that age was not significantly associated [P = 0.110] with family support of inmates. Out of 710 inmates, the majority of them were in the age group of 70 – 79. Among them 68.7% dissatisfied with their family support.

c) It was found that there was a strong correlation between sources of income with regard to family support of inmates since the value was < 0.001 level of significance.

d) Table 8.26 also shows the strong relation of the outside visit of inmates with their family support since the value was < 0.001 level of significance [P = 0.000].

Table 8.25 Association of family support with socio-demographic factors

Socio-demographic factors	Are you satisfied with your Family support?		N=710 Total	P value
	Satisfied	Dissatisfied		
a) Type of home				0.000**
Free home	86 (22.6%)	294 (77.4%)	380 (100%)	
Paid home	124 (45.4%)	149 (54.6%)	273 (100%)	
Free-cum-Paid	17 (29.8%)	40 (70.2%)	57 (100%)	
b) Age				0.110
60-69	51 (40.2%)	76 (59.8%)	127 (100%)	
70-79	96 (31.3%)	211 (68.7%)	307 (100%)	
80-89	67 (27.5%)	177 (72.5%)	244 (100%)	
90-99	13 (40.6%)	19 (59.4%)	32 (100%)	
c) Sources of income				0.000**
Son	46 (41.1%)	66 (58.9%)	112 (100%)	
Daughter	26 (56.5%)	20 (43.5%)	46 (100%)	
Relatives	36 (41.9%)	50 (58.1%)	86 (100%)	
Pension	30 (42.9%)	40 (57.1%)	70 (100%)	
Property	3 (30.0%)	7 (70.0%)	10 (100%)	
None	86 (22.3%)	300 (77.7%)	386 (100%)	
d) Outside visit of inmates				0.000**
Allowed	121 (26.8%)	331 (73.2%)	452 (100%)	
Not allowed	106 (41.1%)	152 (58.9%)	258 (100%)	
Total	227 (32.0%)	483 (68.0%)	710 (100%)	

Note : ** denotes significant at 1% level

CHAPTER IX

Analysis of Health status of inmates

Section 9.1

Table 9.1 Distribution of inmates by their level of satisfaction about their health status (Daily living activities, Medical treatment, Get around)

Health status of inmates		Satisfied			Dissatisfied			Total
		Male	Female	Total	Male	Female	Total	
1) Are you satisfied to perform your daily living activities?	N	110	310	420	72	218	290	710
	%	60.4	58.7	59.2	39.6	41.3	40.8	100
2) Are you satisfied with medical treatment given by home?	N	130	323	453	52	205	257	710
	%	71.4	61.2	63.8	28.6	38.8	36.2	100
3) Are you satisfied to get around?	N	113	319	432	69	209	278	710
	%	62.1	60.4	60.8	37.9	39.6	39.2	100

The above table (9.1) indicates the health status of inmates and their level of satisfaction.

1) 60.4% of male inmates (110) and 58.7% of female inmates (310) were satisfied to perform their daily living activities. Out of 710 inmates, 59.2% of inmates (420) were satisfied and 40.8% of inmates (290) were dissatisfied to perform their daily living activities.
2) 71.4% of male inmates (130) and 61.2% of female inmates (323) were satisfied with the medical treatment given by the old age home. Out of 710 inmates, the majority (63.8%) of inmates (453) was satisfied and 36.2% of inmates (257) were dissatisfied with the medical treatment given by the old age home.
3) 62.1% of male inmates (113) and 60.4% of female inmates (319) were satisfied to get around in old age home. Out of 710 inmates, 60.8% of inmates (432) were satisfied and 39.2% of inmates (278) were dissatisfied to get around in old age home.

Table 9.2 Old age home wise distribution of inmates by the level of satisfaction

District	Old Age Home (OAH)	Are you satisfied to perform Daily living activities?	Are you satisfied with the medical treatment given by home?	Are you satisfied to get around?	Total Inmates N
		Satisfied			
Chennai	OAH -1	50%	87%	53%	84
	OAH -2	43%	45%	63%	81
	OAH -3	60%	47%	53%	40
	OAH -4	57%	70%	57%	30
	OAH -5	59%	59%	59%	27
Kanchee -puram	OAH -6	53%	59%	69%	49
	OAH -7	60%	53%	73%	15
	OAH -8	66%	66%	53%	38
	OAH -9	66%	63%	53%	32
	OAH -10	65%	58%	50%	26
Vellore	OAH -11	76%	50%	76%	38
	OAH -12	54%	58%	54%	24
	OAH -13	71%	53%	71%	21
	OAH -14	67%	47%	67%	15
	OAH -15	64%	42%	64%	36
Thiru -vallur	OAH -16	69%	86%	70%	62
	OAH -17	75%	83%	50%	12
	OAH -18	67%	84%	99%	6
	OAH -19	59%	85%	64%	66
	OAH -20	38%	99%	57%	8
Total		420	453	432	710
		59.2%	63.8%	60.8%	100 %

Table 9.3 indicates the health status of inmates and their level of satisfaction.

4) 59.9% of male inmates (109) and 55.3% of female inmates (292) were satisfied with their sleep. Out of 710 inmates, 56.5% of inmates (401) were satisfied and 43.5% of inmates (309) were dissatisfied with their sleep.

5) 64.3% of male inmates (117) and 55.3% of female inmates (292) were satisfied with their capacity for work. Out of 710 inmates, 57.6% of inmates (409) were satisfied and 42.4% of inmates (301) were dissatisfied with their capacity for work.

6) 70.3% of male inmates (128) and 60.8% of female inmates (321) were satisfied with their memory. Out of 710 inmates, 63.2% of inmates (449) were satisfied and 36.8% of inmates (261) were dissatisfied with their memory.

Table 9.3 Level of satisfaction of inmates (sleep, work, and memory)

Health status of inmates		Satisfied			Dissatisfied			Total
		Male	Female	Total	Male	Female	Total	
4) Are you satisfied with your sleep?	N	109	292	401	73	236	309	710
	%	59.9	55.3	56.5	40.1	44.7	43.5	100
5) Are you satisfied with your capacity for work?	N	117	292	409	65	236	301	710
	%	64.3	55.3	57.6	35.7	44.7	42.4	100
6) Are you satisfied with your memory?	N	128	321	449	54	207	261	710
	%	70.3	60.8	63.2	29.7	39.2	36.8	100

Table 9.4 Old age home wise distribution of inmates by the level of satisfaction (sleep, work, and memory)

District	Old Age Home (OAH)	Are you satisfied with your sleep?	Are you satisfied with your capacity for work?	Are you satisfied with your memory?	Total Inmates N
		Satisfied			
Chennai	OAH -1	35%	58%	37%	84
	OAH -2	67%	61%	35%	81
	OAH -3	53%	53%	83%	40
	OAH -4	57%	57%	57%	30
	OAH -5	48%	70%	59%	27
Kanchee -puram	OAH -6	35%	43%	76%	49
	OAH -7	27%	34%	73%	15
	OAH -8	63%	68%	71%	38
	OAH -9	66%	66%	69%	32
	OAH -10	58%	46%	46%	26
Vellore	OAH -11	61%	61%	76%	38
	OAH -12	38%	38%	54%	24
	OAH -13	52%	52%	71%	21
	OAH -14	40%	40%	67%	15
	OAH -15	41%	44%	64%	36
Thiru vallur	OAH -16	71%	71%	84%	62
	OAH -17	75%	75%	92%	12
	OAH -18	83%	67%	50%	6
	OAH -19	77%	61%	82%	66
	OAH -20	75%	88%	63%	8
Total		401	409	448	710
		57%	58%	63%	100 %

Table 9.5 Distribution of inmates by the level of satisfaction (health services, health status, energy level)

Health status of inmates		Satisfied			Dissatisfied			Total
		Male	Female	Total	Male	Female	Total	
7) Are you satisfied with access to health services?	N	135	342	477	47	186	233	710
	%	74.2	64.8	67.2	25.8	35.2	32.8	100
8) Are you satisfied with your health status?	N	119	283	402	63	245	308	710
	%	65.4	53.6	56.6	34.6	46.4	43.4	100
9) Are you satisfied with your energy level for everyday life?	N	114	287	401	68	241	309	710
	%	62.6	54.4	56.5	37.4	45.6	43.5	100

The above table (9.5) indicates the health status of inmates and their level of satisfaction.

7) 74.2% of male inmates (135) and 64.8% of female inmates (342) were satisfied with access to health services. Out of 710 inmates, 67.2% of inmates (477) were satisfied and 32.8% of inmates (233) were dissatisfied with access to health services.

8) 65.4% of male inmates (119) and 53.6% of female inmates (283) were satisfied with their health status. Out of 710 inmates, 56.6% of inmates (402) were satisfied and 43.4% of inmates (308) were dissatisfied with their health status.

9) 62.6% of male inmates (114) and 54.4% of female inmates (287) were satisfied with their energy level for everyday life. Out of 710 inmates, 56.5% of inmates (401) were satisfied and 43.5% of inmates (309) were dissatisfied with their energy level for everyday life.

Table 9.6 Old age home wise distribution of inmates by the level of satisfaction

District	Old age home (OAH)	Are you satisfied with access to health services?	Are you satisfied with your health status?	Are you satisfied with your energy level for everyday life?	Total Inmates N
		Satisfied			
Chennai	OAH -1	61%	37%	35%	84
	OAH -2	61%	41%	58%	81
	OAH -3	85%	43%	90%	40
	OAH -4	63%	50%	47%	30
	OAH -5	70%	59%	59%	27
Kanchee -puram	OAH -6	61%	55%	57%	49
	OAH -7	80%	40%	47%	15
	OAH -8	66%	71%	66%	38
	OAH -9	65%	66%	66%	32
	OAH -10	54%	54%	65%	26
Vellore	OAH -11	63%	53%	60%	38
	OAH -12	58%	38%	38%	24
	OAH -13	62%	48%	52%	21
	OAH -14	60%	40%	40%	15
	OAH -15	58%	42%	44%	36
Thiru -vallur	OAH -16	79%	87%	63%	62
	OAH -17	83%	92%	67%	12
	OAH -18	83%	98%	50%	6
	OAH -19	77%	86%	62%	66
	OAH -20	87%	88%	62%	8
Total		477	402	401	710
		67%	57%	57%	100 %

Table 9.7 explains the distribution of inmates and their ailments.

1) 60.4% of male inmates (110) and 65.2% of female inmates (344) were affected by arthritis. Out of 710 inmates, 63.9% of inmates (454) were affected by arthritis.
2) 49.5% of male inmates (90) and 55.3% of female inmates (292) were affected by Cataract. Totally, 53.8% of inmates (382) were affected by Cataract.
3) 61.5% of male inmates (112) and 62.1% of female inmates (328) lost their natural teeth. Some inmates were using denture.
4) 56.2% of inmates (399) were affected by High blood pressure.
5) 54.4% of male inmates (99) and 52.5% of female inmates (277) were affected by Diabetes. Out of 710 inmates, 53.0% of inmates (376) were affected by Diabetes.
6) 25.3% of male inmates (46) and 29.0% of female inmates (153) were affected by Asthma (28.0%).

Table 9.7 Distribution of inmates affected by the following ailments

Ailments		Yes			No			Total
		Male	Female	Total	Male	Female	Total	
1)Arthritis	N	110	344	454	72	184	256	710
	%	60.4	65.2	63.9	39.6	34.8	36.1	100
2)Cataract	N	90	292	382	92	236	328	710
	%	49.5	55.3	53.8	50.5	44.7	46.2	100
3)Loss of teeth	N	112	328	440	70	200	270	710
	%	61.5	62.1	62.0	38.5	37.9	38.0	100
4)High blood pressure	N	106	293	399	76	235	311	710
	%	58.2	55.5	56.2	41.8	44.5	43.8	100
5)Diabetes	N	99	277	376	83	251	334	710
	%	54.4	52.5	53.0	45.6	47.5	47.0	100
6)Asthma	N	46	153	199	136	375	511	710
	%	25.3	29.0	28.0	74.7	71.0	72.0	100

Table 9.8 Home wise distribution of inmates and their ailments

District	Old age home (OAH)	Are you affected by the following ailments?			Total Inmates N
		Arthritis	Cataract	Loss of teeth	
		Yes			
Chennai	OAH -1	66%	48%	58%	84
	OAH -2	56%	43%	54%	81
	OAH -3	75%	65%	53%	40
	OAH -4	67%	40%	50%	30
	OAH -5	59%	52%	67%	27
Kanchee -puram	OAH -6	65%	59%	49%	49
	OAH -7	67%	60%	47%	15
	OAH -8	55%	50%	66%	38
	OAH -9	50%	59%	69%	32
	OAH -10	69%	46%	69%	26
Vellore	OAH -11	61%	55%	66%	38
	OAH -12	54%	58%	58%	24
	OAH -13	62%	67%	86%	21
	OAH -14	80%	67%	67%	15
	OAH -15	56%	64%	62%	36
Thiru -vallur	OAH -16	65%	66%	66%	62
	OAH -17	83%	83%	83%	12
	OAH -18	99%	67%	50%	6
	OAH -19	77%	41%	77%	66
	OAH -20	38%	38%	38%	8
Total		454	382	440	710
		64%	54%	62%	100 %

Table 9.8 explains the distribution of inmates and their ailments by the old age homes. Highest percentages of inmates were affected by arthritis (99%) and cataract (83%) in Thiruvallur district. In Vellore district, 86% of inmates were affected by the loss of teeth.

Table 9.9 Home wise distribution of inmates and their ailments

District	Old age home (OAH)	Are you affected by the following ailments?			Total Inmates N
		High blood pressure	Diabetes	Asthma	
		Yes			
Chennai	OAH -1	69%	57%	32%	84
	OAH -2	48%	73%	14%	81
	OAH -3	67%	58%	20%	40
	OAH -4	67%	63%	33%	30
	OAH -5	74%	74%	37%	27
Kanchee -puram	OAH -6	61%	57%	39%	49
	OAH -7	47%	67%	67%	15
	OAH -8	58%	42%	37%	38
	OAH -9	50%	47%	22%	32
	OAH -10	50%	65%	27%	26
Vellore	OAH -11	45%	37%	29%	38
	OAH -12	42%	33%	25%	24
	OAH -13	38%	48%	29%	21
	OAH -14	47%	40%	14%	15
	OAH -15	47%	47%	22%	36
Thiru -vallur	OAH -16	48%	40%	29%	62
	OAH -17	58%	33%	8.5%	12
	OAH -18	50%	17%	67%	6
	OAH -19	65%	48%	29%	66
	OAH -20	63%	50%	13%	8
Total		399	376	199	710
		56%	53%	98	100 %

Table 9.10 elaborates the distribution of inmates affected by cancer, paralysis and Alzheimer, Dementia, Heart disease and renal disease.

1) 1.1% of male inmates (2) and 1.5% of female inmates (8) were affected by the disease cancer. Out of 710 inmates, 10 inmates (1.4%) were affected by cancer and taking medicine for the disease.
2) 4 inmates (0.6%) were affected by paralysis, out of them 3 were male inmates (1.6%) and 1 was a female inmate (0.2%).

3) 0.5% of male inmates (1) and 0.4% of female (2) inmates were affected by Alzheimer. Out of 710 inmates, 3 inmates (0.4%) were affected by Alzheimer.
4) Out of 710 inmates, no one was (0.0%) affected by dementia.
5) 54 inmates (7.6%) were affected by heart disease, out of them 10 were male inmates (5.5%) and 44 were female inmates (8.3%).
6) 2.7% of male inmates (5) and 1.1% of female (6) inmates were affected by renal disease. On the whole, 11 inmates (1.5%) were affected by renal disease.

Table 9.10 Distribution of inmates by their diseases (1)

Diseases		Yes			No		
		Male	Female	Total	Male	Female	Total
1) Cancer	N	2	8	10	180	520	700
	%	1.1	1.5	1.4	98.9	98.5	98.6
2) Paralysis	N	3	1	4	179	527	706
	%	1.6	0.2	0.6	98.4	99.8	99.4
3) Alzheimer	N	1	2	3	181	526	707
	%	0.5	0.4	0.4	99.5	99.6	99.6
4) Dementia	N	0	0	0	182	528	710
	%	0.0	0.0	0.0	100	100	100
5) Heart disease	N	10	44	54	172	484	656
	%	5.5	8.3	7.6	94.5	91.7	92.4
6) Renal disease	N	5	6	11	177	522	699
	%	2.7	1.1	1.5	97.3	98.9	98.5

Table 9.11 Distribution of inmates by their diseases (2)

Diseases		Yes			No		
		Male	Female	Total	Male	Female	Total
7) Skin disease	N	8	37	45	174	491	665
	%	4.4	7.0	6.3	95.6	93.0	93.7
8) Lung disease	N	4	29	33	178	499	677
	%	2.2	5.5	4.6	97.8	94.5	95.4
9) Liver disease	N	0	0	0	182	528	710
	%	0.0	0.0	0.0	100	100	100

The above table (9.11) elaborates the distribution of inmates affected by Skin disease, Lung disease and Liver disease.

7) 4.4% of male inmates (8) and 7.0% of female inmates (37) were affected by the skin disease. Out of 710 inmates, 45 inmates (6.3%) were affected by skin disease.

8) 33 inmates (4.6%) were affected by lung disease. Among them 4 were male inmates (2.2%) and 29 were female inmate (5.5%).

9) Out of 710 inmates, no one was affected (0.0%) by the liver disease**.**

Table 9.12 Distribution of inmates by their risky health behaviour

Risky health behaviour		Yes			No			Total
		Male	Female	Total	Male	Female	Total	
Smoking	N	2	0	2	180	528	708	710
	%	1.1	0.0	0.3	98.9	100	99.7	100
Alcohol consumption	N	0	0	0	182	528	710	710
	%	0.0	0.0	0.0	100	100	100	100
Chewing tobacco	N	2	3	5	180	525	705	710
	%	1.1	0.6	0.7	98.9	99.4	99.3	100

Table 9.12 reveals the risky health behaviour of inmates in old age home. Out of 710 inmates, 2 male inmates (1.1%) had the habit of smoking. Some paid home inmates continue the habit of smoking in their rooms. No one (0.0%) had the habit of alcohol consumption. 2 male inmates (1.1%) and 3 female inmates (0.6%) had the risky health behaviour of chewing tobacco. In Thiruvallur and Vellore district some inmates continue using tobacco.

Table 9.13 shows the inmates' usage of medicines. Out of 710 inmates, 624 inmates (87.9%) were using medicines; only 86 inmates (12.1%) were not using medicines. 46.2% of male inmates and 45.6% of female inmates had been using medicines for diabetes. But majority of inmates (54.2%) were not using medicine for diabetes. 23.1% of male inmates (42) and 29% of female inmates (153) were using medicines for pain, but majority of inmates (72.5%) were not using medicines for pain. 39% of male inmates and 33.7% of female inmates were using medicines for other diseases. But 64.9% of inmates were not using medicine for other diseases.

Table 9.13 Distribution of inmates and their use of medicines

Use of medicines		Yes			No			Total
		Male	Female	Total	Male	Female	Total	
1. Do you use medicines?	N	141	483	624	41	45	86	710
	%	77.5	91.5	87.9	22.5	8.5	12.1	100
2. Do you use medicine for diabetes?	N	84	241	325	98	287	385	710
	%	46.2	45.6	45.8	53.8	54.4	54.2	100
3. Do you use medicine for pain?	N	42	153	195	140	375	515	710
	%	23.1	29.0	27.5	76.9	71.0	72.5	100
4. Do you use medicine for other diseases?	N	71	178	249	111	350	461	710
	%	39.0	33.7	35.1	61.0	66.3	64.9	100

Table 9.14 Distribution of inmates and their medical care

Where do you get most of your Medical care?		Yes			No		
		Male	Female	Total	Male	Female	Total
General hospital	N	72	195	267	110	333	443
	%	39.6	36.9	37.6	60.4	63.1	62.4
Private hospital	N	56	150	206	126	378	504
	%	30.8	28.4	29.0	69.2	71.6	71.0
Dispensary	N	59	155	214	123	373	496
	%	32.4	29.4	30.1	67.6	70.6	69.9
Self-medication	N	61	181	242	121	347	468
	%	33.5	34.3	34.1	66.5	65.7	65.9
In old age home	N	106	339	445	76	189	265
	%	58.2	64.2	62.7	41.8	35.8	37.3

The above table (9.14) shows the distribution of inmates and their medical care. Majority of inmates (445) stated that they get medicines from their old age home. Medicines for fever, cough, cold, diarrhoea, stomach ache, arthritis, high blood pressure, diabetes, asthma and skin diseases, were provided by the old age home.

39.6% of male inmates (72) and 36.9% of female inmates (195) were getting most of their medical care from the nearby general hospital. 33.5% of male inmates (61) and 34.3% of female inmates (181) were using self-medication. 32.4% of male inmates

(59) and 29.4% of female inmates (155) were getting most of their medical care from dispensary. Only 29% of inmates (206) were getting medical care from private hospital.

Table 9.15 Problems in health care center

Problems in health care centre		District				Total
		Chennai	Kanchee puram	Vellore	Thiruv allur	
Yes	N	58	26	45	17	146
	%	22.1	16.2	33.6	11.0	20.6
No	N	204	134	89	137	564
	%	77.9	83.8	66.4	89.0	79.4
Total	N	262	160	134	154	710
	%	100	100	100	100	100

The above table (9.15) reveals that 20.6% of inmates (146) had problems in health care centre. Particularly in Vellore district out of five homes, four old age homes were free homes and majority of inmates (33.6%) had problems in health care centre. 22.1% of inmates had problems in Chennai district, 16.2% of inmates had problems in Kancheepuram district and 11% of inmates had problems in Thiruvallur district.

Table 9.16.1 reveals the distribution of inmates by their availability of food items. 100% of inmates (710) stated that every day they get rice in their food. 99.4% of inmates stated that wheat was rarely available in their food items. Only 4 inmates (0.6%) mentioned that they get wheat every day. 97.7% of inmates (694) stated that jower/ragi were rarely available in their food items. Only 16 inmates (2.3%) mentioned that jower/ragi was available every day in their food items.

Table 9.16.2 reveals that 25.1% of inmates were rarely getting the food egg/meat/fish. Majority of old age homes run by Christian missionaries and they provide non-vegetarian to their inmates. 74.9% of inmates were getting only vegetarian food items. 100% of the inmates were getting vegetables every day. 91.0% of inmates stated that they get dal every day. 9.0% of inmates were rarely getting the dal.

Table 9.16.1 Availability of food items in old age home (1)

Availability of food items			Every day	Rarely	Never	Total
Rice	Male	N	182	0	0	182
		%	100	0.0	0.0	100
	Female	N	528	0	0	528
		%	100	0.0	0.0	100
Total		N	710	0	0	710
		%	100	0.0	0.0	100
Wheat	Male	N	1	181	0	182
		%	0.5	99.5	0.0	100
	Female	N	3	525	0	528
		%	0.6	99.4	0.0	100
Total		N	4	706	0	710
		%	0.6	99.4	0.0	100
Jower/ Ragi	Male	N	2	180	0	182
		%	1.1	98.9	0.0	100
	Female	N	14	514	0	528
		%	2.7	97.3	0.0	100
Total		N	16	694	0	710
		%	2.3	97.7	0.0	100

Table 9.16.2 Availability of food items in old age home (2)

Availability of food items			Every day	Rarely	Never	Total
Egg/ Meat/ Fish	Male	N	0	37	145	182
		%	0.0	20.3	79.7	100
	Female	N	0	141	387	528
		%	0.0	26.7	73.3	100
Total		N	0	178	532	710
		%	0.0	25.1	74.9	100
Vegeta -bles	Male	N	182	0	0	182
		%	100	0.0	0.0	100
	Female	N	528	0	0	528
		%	100	0.0	0.0	100
Total		N	710	0	0	710
		%	100	0.0	0.0	100
Dal	Male	N	164	18	0	182
		%	90.1	9.9	0.0	100
	Female	N	482	46	0	528
		%	91.3	8.7	0.0	100
Total		N	646	64	0	710
		%	91.0	9.0	0.0	100

Table 9.17 Availability of milk items in old age home

Availability of milk items			Every day	Rarely	Never	Total
Milk / Curd	Male	N	181	1	0	182
		%	99.5	0.5	0.0	100
	Female	N	524	4	0	528
		%	99.2	0.8	0.0	100
Total		N	705	5	0	710
		%	99.3	0.7	0.0	100
Butter/ Ghee	Male	N	12	42	128	182
		%	6.6	23.1	70.3	100
	Female	N	43	165	320	528
		%	8.1	31.2	60.6	100
Total		N	55	207	448	710
		%	7.7	29.2	63.1	100
Butter milk	Male	N	50	132	0	182
		%	27.5	72.5	0.0	100
	Female	N	165	363	0	528
		%	31.2	68.8	0.0	100
Total		N	215	495	0	710
		%	30.3%	69.7	0.0	100

The above table (9.17) reveals the distribution of inmates by their availability of food items.

99.3% of inmates stated that every day the home is providing milk to the inmates. Only 0.7% of inmates were rarely getting milk/curd products. 7.7% of inmates stated that butter /ghee was available every day in their food items. 29.2% of inmates stated rarely available and for majority (63.1%) of inmates, butte /ghee was not available. Buttermilk was rarely available to majority of inmates (495) and 30.3% of inmates were getting the buttermilk every day.

Table 9.18 explains the distribution of inmates and the availability of nutritionally balanced food. Majority (79.7%) of inmates (566) stated that the food they get is nutritionally adequate. But 15.6% of inmates (111) stated, their food is nutritionally inadequate. 4.6% of inmates (33) were uncertain about their food. Majority of inmates from free homes were satisfied with their food.

Table 9.18 Distribution of inmates by the availability of nutritional food

District	Old age home (OAH)	Do you think the food is nutritionally adequate?			Total Inmates N
		Adequate	Inadequate	Uncertain	
Chennai	OAH -1	99%	0%	1%	84
	OAH -2	99%	1%	0%	81
	OAH -3	98%	2%	0%	40
	OAH -4	60%	40%	0%	30
	OAH -5	82%	17%	1%	27
Kanchee -puram	OAH -6	99%	1%	0%	49
	OAH -7	98%	2%	0%	15
	OAH -8	61%	19%	20%	38
	OAH -9	63%	20%	17%	32
	OAH -10	58%	20%	22%	26
Vellore	OAH -11	79%	11%	10%	38
	OAH -12	79%	13%	8%	24
	OAH -13	81%	10%	9%	21
	OAH -14	73%	14%	13%	15
	OAH -15	81%	9%	10%	36
Thiru -vallur	OAH -16	60%	40%	0%	62
	OAH -17	67%	33%	0%	12
	OAH -18	66%	35%	0%	6
	OAH -19	58%	42%	0%	66
	OAH -20	75%	25%	0%	8
Total		566	111	33	710
		79.7%	15.6%	4.6%	100 %

9.2 Short Form – 36 Health Survey 1.0 Questionnaire Items

Table 9.19 Distribution of inmates by their health status

1) In general your health is		Gender		Total
		Male	Female	
Excellent	N	22	36	58
	%	12.1	6.8	8.2
Very good	N	44	87	131
	%	24.2	16.5	18.5
Good	N	72	186	258
	%	39.6	35.2	36.3
Fair	N	27	118	145
	%	14.8	22.3	20.4
Poor	N	17	101	118
	%	9.3	19.1	16.6
Total	N	182	528	710
	%	100	100	100

Table 9.19 shows the distribution of inmates and their health status. 8.2% of inmates (58) stated that in general, their health status was excellent. Out of them, 12.1% were male inmates and 6.8% were female inmates. 18.5% of inmates stated that (131) their health status was very good. 36.3% of inmates (258) stated that their health status was good, 20.4% of inmates (145) health condition was fair, 9.3% of male inmates (17) and 19.1% of female inmates (101) health status was poor. Out of 710 inmates, 16.6% of inmates (118) health condition was poor.

Table 9.20 Home wise Distribution of inmates and their health status

District	Old age home (OAH)	In general how do you feel about your health?					N
		Excellent	Very good	Good	Fair	Poor	
Chennai	OAH -1	0%	14%	46%	12%	28%	84
	OAH -2	0%	22%	37%	29%	12%	81
	OAH -3	0%	0%	37%	40%	23%	40
	OAH -4	0%	10%	40%	33%	17%	30
	OAH -5	0%	22%	44%	22%	12%	27
Kanchee -puram	OAH -6	10%	18%	32%	26%	14%	49
	OAH -7	0%	7%	20%	40%	33%	15
	OAH -8	8%	16%	50%	13%	13%	38
	OAH -9	3%	12%	37%	21%	27%	32
	OAH -10	8%	8%	42%	19%	23%	26
Vellore	OAH -11	8%	13%	42%	21%	16%	38
	OAH -12	4%	12%	33%	33%	18%	24
	OAH -13	0%	9%	28%	38%	25%	21
	OAH -14	13%	0%	27%	33%	27%	15
	OAH -15	3%	11%	50%	16%	20%	36
Thiru -vallur	OAH -16	11%	42%	42%	0%	5%	62
	OAH -17	50%	33%	8%	8%	1%	12
	OAH -18	33%	50%	16%	0%	1%	6
	OAH -19	30%	32%	12%	9%	17%	66
	OAH -20	25%	25%	12%	12%	26%	8
Total		58 8.2%	131 18.5%	258 36.3%	145 20.4%	118 16.6%	710 100 %

Table 9.21 reveals the health status of inmates compared to one year ago. The inmates rated their health in general. Compared to one year ago, 5.1% of inmates (36) health status was much better now, 20.3% of inmates (144) health status was somewhat better now, 32.5% of inmates' (231) health status was about the same now.

25.6% of inmates (182) health status was somewhat worse now and 16.5% of inmates (117) health status was much worse now compared to one year ago.

Table 9.21 Inmates and their health status (compared to one year ago)

2) Compared to one year ago, your health is		Gender		Total
		Male	Female	
Much better	N	11	25	36
	%	6.0	4.7	5.1
Somewhat better	N	44	100	144
	%	24.2	18.9	20.3
About the same	N	62	169	231
	%	34.1	32.0	32.5
Somewhat worse	N	41	141	182
	%	22.5	26.7	25.6
Much worse	N	24	93	117
	%	13.2	17.6	16.5
Total	N	182	528	710
	%	100.0	100.0	100.0

Table 9.22 Inmates' activities (Vigorous, Moderate and lifting activities)

A) Does your health now limit you in activities?			Yes, limited a lot	Yes, limited a little	No, not limited at all	Total
3)Vigorous activities	Male	N	39	96	47	182
		%	21.4	52.7	25.8	100
	Female	N	137	247	144	528
		%	25.9	46.8	27.3	100
Total		N	176	343	191	710
		%	24.8	48.3	26.9	100
4)Moderate activities	Male	N	32	91	59	182
		%	17.6	50.0	32.4	100
	Female	N	127	227	174	528
		%	24.1	43.0	33.0	100
Total		N	159	318	233	710
		%	22.4	44.8	32.8	100
5)Lifting or carrying groceries	Male	N	46	80	56	182
		%	25.3	44.0	30.8	100
	Female	N	141	245	142	528
		%	26.7	46.4	26.9	100
Total		N	187	325	198	710
		%	26.3	45.8	27.9	100

Table 9.22 shows the distribution of inmates and some activities. The data show how the activities were limited by their health condition.

3) 24.8% of inmates (176) vigorous activities were limited a lot, 48.3% of inmates (343) vigorous activities were limited a little and 26.9% of inmates' vigorous activities were not limited at all by their health condition.

4) 22.4% of inmates (159) moderate activities were limited a lot, 44.8% of inmates (318) moderate activities were limited a little and 32.8% of inmates' moderate activities (233) were not limited at all by their health condition.

5) 26.3% of inmates (187) lifting or carrying activities were limited a lot, and 27.9% of inmates' lifting activities (198) were not limited at all by their health condition.

Table 9.23 Distribution of inmates and their activities (Climbing several stairs, some stairs and Bending)

B) Does your health now limit you in activities?			**Yes, limited a lot**	**Yes, limited a little**	**No, not limited at all**	**Total**
6)Climbing several stairs	Male	N	62	83	37	182
		%	34.1	45.6	20.3	100
	Female	N	182	242	104	528
		%	34.5	45.8	19.7	100
Total		N	244	325	141	710
		%	34.4	45.8	19.9	100
7)Climbing some stairs	Male	N	19	90	73	182
		%	10.4	49.5	40.1	100
	Female	N	114	231	183	528
		%	21.6	43.8	34.7	100
Total		N	133	321	256	710
		%	18.7	45.2	36.1	100
8)Bending, Kneeling or stooping	Male	N	22	75	85	182
		%	12.1	41.2	46.7	100
	Female	N	95	217	216	528
		%	18.0	41.1	40.9	100
Total		N	117	292	301	710
		%	16.5	41.1	42.4	100

The above table (9.23) shows the distribution of inmates by their activities. The data show how the activities were limited by their health condition.

6) 34.4% of inmates (244) activity of climbing several stairs were limited a lot, 45.8% of inmates (325) activity of climbing several stairs were limited a little and 19.9% of inmates' activity of (141) climbing several stairs were not limited at all by their health condition.

7) The activity of climbing some stairs was limited a lot to 18.7 % of inmates, limited a little to 45.2% inmates and not limited to 36.1% of inmates.

8) The activity of bending was limited a lot to 18.0 % inmates, limited a little to 41.1% inmates and not limited to 42.4% of inmates.

Table 9.24 Distribution of inmates and their activities
(Walking a mile, several blocks, one block and bathing)

C) Does your health now limit you in activities?			**Yes, limited a lot**	**Yes, limited a little**	**No, not limited at all**	**Total**
9.Walking more than a mile	Male	N	55	80	47	182
		%	30.2	44.0	25.8	100
	Female	N	164	229	135	528
		%	31.1	43.4	25.6	100
Total		N	219	309	182	710
		%	30.8	43.5	25.6	100
10.Walking several blocks	Male	N	41	90	51	182
		%	22.5	49.5	28.0	100
	Female	N	142	246	140	528
		%	26.9	46.6	26.5	100
Total		N	183	336	191	710
		%	25.8	47.3	26.9	100
11.Walking one block	Male	N	21	68	93	182
		%	11.5	37.4	51.1	100
	Female	N	96	184	248	528
		%	18.2	34.8	47.0	100
Total		N	117	252	341	710
		%	16.5	35.5	48.0	100
12.Bathing or dressing yourself	Male	N	14	69	99	182
		%	7.7	37.9	54.4	100
	Female	N	89	168	271	528
		%	16.9	31.8	51.3	100
Total		N	103	237	370	710
		%	14.5	33.4	52.1	100

The above table (9.24) shows the distribution of inmates and some activities. The data show how the activities were limited by their health condition.

9) The activity of walking more than a mile was limited a lot to 30.8 % inmates, limited a little to 43.5% inmates and not limited to 25.6% of inmates.

10) The activity of walking several blocks was limited a lot to 25.8% inmates, limited a little to 47.3% inmates and not limited to 26.9% of inmates.

11) The activity of walking one block was limited a lot to 16.5 % inmates, limited a little to 35.5% inmates and not limited to 48.0% of inmates.

12) The activity of bathing or dressing themselves were limited a lot to 14.5% inmates, limited a little to 33.4% inmates and not limited to 52.1% of inmates.

Table 9.25 Distribution of inmates and their problems as a result of Physical health

Have you had any of the following problems as a result of your physical health?		**Yes**	**No**	**Total**
13.Work or other activities reduced	N	368	342	710
	%	51.8	48.2	100
14.Accomplished less than you would like	N	350	360	710
	%	49.3	50.7	100
15.Work or other activities limited	N	315	395	710
	%	44.4	55.6	100
16.Difficulty in activities	N	324	386	710
	%	45.6	54.4	100

The above table 9.25 shows the distribution of inmates and their problems as a result of physical health

13) As a result of their physical health, 51.8% of inmates (368) had problems with work or other activities,

14) 49.3% of inmates (350) accomplished less than they like,

15) 44.4% of inmates' (315) work or other activities limited and

16) 45.6% of inmates (324) had difficulty in performing the work or other activities.

Table 9.26 explains how emotional problems affect the activities of inmates.

17)As a result of emotional problems, 40.4% of inmates' (287) daily activities had reduced,

18) 45.4% of inmates (322) accomplished less than they like and

19)46.9% of inmates (333) did not do activities as carefully as usual.

Table 9.26

Have you had any of the following problems with daily activities as a result of **Emotional problems?**		**Yes**	**No**	**Total**
17) Activities reduced	N	287	423	710
	%	40.4	59.6	100.0
18) Accomplished less than you would like	N	322	388	710
	%	45.4	54.6	100.0
19) Didn't do activities as carefully as usual	N	333	377	710
	%	46.9	53.1	100.0

Table 9.27 Distribution of inmates and their problems with social activities

20) To what extent has your physical and emotional problems interfered with your **Social activities**?						
Five point scale	Male		Female		Total	
	N	%	N	%	N	%
Not at all	38	20.9	92	17.4	130	18.3
Slightly	85	46.7	200	37.9	285	40.1
Moderately	39	21.4	138	26.1	177	24.9
Quite a bit	18	9.9	76	14.4	94	13.2
Extremely	2	1.1	22	4.2	24	3.4
Total	182	100.0	528	100.0	710	100.0

The above table (9.27) explains to what extent the physical and emotional problems interfered with inmates' social activities. 18.3% of inmates (130) stated that their physical and social activities were not at all interfered with their social activities. 40.1% of inmates' activities (285) slightly interfered, 24.9% of inmates' activities (177) moderately interfered, 13.2% of inmates' activities (94) quite a bit interfered and 3.4% of inmates (24) extremely interfered with their social activities because of physical and emotional problems.

Table 9.28 explains how much body pain the inmates had during the past four weeks. Out of 710 inmates, 12.3% of inmates did not have body pain, 45.8% of inmates had very mild body pain, 24.1% of inmates had mild pain, 8.3% of inmates had got pain moderately, 8.2% of inmates had severe pain and 1.4% of inmates had very severe pain during the past four weeks.

Table 9.28 Body pain of inmates

21)How much bodily pain have you had during the past 4 weeks?	Gender				Total	
	Male		Female			
	N	%	N	%	N	%
None	29	15.9	58	11.0	87	12.3
Very mild	94	51.6	231	43.8	325	45.8
Mild	42	23.1	129	24.4	171	24.1
Moderately	5	2.7	54	10.2	59	8.3
Severe	11	6.0	47	8.9	58	8.2
Very severe	1	0.5	9	1.7	10	1.4
Total	182	100	528	100	710	100

Table 9.29 explains the distribution of inmates and how much pain interfered with their normal work. 22.7% of inmates' body pain not at all interfered with their normal work. 34.4% of inmates' pain interfered a little bit with their normal work. 22.7% of inmates' pain moderately interfered with their normal work. 16.8% of inmates' pain interfered quite a bit interfered and 3.5% of inmates' pain extremely interfered with their normal work.

Table 9.29 Distribution of inmates by their pain

22)How much did pain interfere with your normal work?	Gender				Total	
	Male		Female			
	N	%	N	%	N	%
Not at all	47	25.8	114	21.6	161	22.7
A little bit	76	41.8	168	31.8	244	34.4
Moderately	34	18.7	127	24.1	161	22.7
Quite a bit	21	11.5	98	18.6	119	16.8
Extremely	4	2.2	21	4.0	25	3.5
Total	182	100	528	100	710	100

Table 9.30 explains the distribution of inmates and how do they feel during the past 4 weeks.

23) 5.9% of inmates (42) all the time felt full of energy, 15.1% of inmates (107) most of the time, felt full of energy. 18.6% of inmates (132) felt full of energy, a good bit of time, 33.5% of inmates (238) felt full of energy, some of the time, 22.3% of

inmates (158) felt full of energy, little of the time and 4.6% of inmates (33) none of the time, felt full of energy.

24) 4.4% of inmates (31) were nervous person all of the time. 8.6% of inmates (61) were most of the time became nervous. 17.2% of inmates (122) became nervous a good bit of time. Majority (34.9%) of inmates (248) became nervous some of the time. 22% of inmates (156) rarely became nervous and 13% of inmates (92) never became nervous for any reason.

25) Inmates have felt that nothing could cheer them up, but only 5.1 % of inmates felt all of the time, 14.5% of inmates felt most of the time, 20.3% of inmates felt a good bit of time, majority of inmates (271) felt some of the time, 19.3% of inmates felt little of the time and 2.7% of inmates (19) felt little of the time.

26) Majority (33.2%) of inmates(236) most of the time felt calm and peaceful, 32.3% of inmates felt a good bit of time, 20.3% of inmate felt some of the time, 7.2% of inmates felt a little of the time, but 7.0% of inmates felt calm and peaceful all of the time.

Table 9.30 How do they feel? (Q23 to Q26)

How do you feel?		All of the time	Most of the time	A good bit of time	Some of the time	Little of the time	None of the time	Total
23) Did you feel full of pep?	N	42	107	132	238	158	33	710
	%	5.9	15.1	18.6	33.5	22.3	4.6	100
24) Have you been a very nervous person?	N	31	61	122	248	156	92	710
	%	4.4	8.6	17.2	34.9	22.0	13.0	100
25) Have you felt that nothing could cheer you up?	N	36	103	144	271	137	19	710
	%	5.1	14.5	20.3	38.2	19.3	2.7	100
26) Have you felt calm and peaceful?	N	50	236	229	144	51	0	710
	%	7.0	33.2	32.3	20.3	7.2	0.0	100

Table 9.31 explains the distribution of inmates and how do they feel during the past 4 weeks. 27) Majority of inmates (238) had a lot of energy some of the time and only 2.0% of inmates (14) had a lot of energy all the time.

28) Out of 710 inmates, many inmates felt downhearted and blue, 2% of them felt all of the time, but 28.3% of them felt some of the time.

29) Majority of inmates (274) stated that some of the time they felt extremely tired and 2.7% of inmates did not feel extremely tired. 8.6% of inmates all the time felt extremely tired.

30) 3.0% of inmates were happy all of the time but, 2.1% of inmates stated that they were not at all happy. Majority of inmates (212) were happy some of the time.

31) Majority (32.3%) of inmates felt tired some of the time, 26.2% of inmates felt tired little of the time and 2.1% of inmates did not feel tired.

Table 9.31 How do they feel? (Q27 to Q31)

How do you feel?		All of the time	Most of the time	A good bit of time	Some of the time	Little of the time	None of the time	Total
27)Did you have a lot of energy?	N	14	98	140	238	162	58	710
	%	2.0	13.8	19.7	33.5	22.8	8.2	100
28)Have you felt down hearted and blue?	N	14	170	170	201	155	0	710
	%	2.0	23.9	23.9	28.3	21.8	0.0	100
29)Did you feel worn out?	N	61	98	128	274	130	19	710
	%	8.6	13.8	18.0	38.6	18.3	2.7	100
30)Have you been a happy person?	N	21	139	172	212	151	15	710
	%	3.0	19.6	24.2	29.9	21.3	2.1	100
31)Did you feel tired?	N	64	109	107	229	186	15	710
	%	9.0	15.4	15.1	32.3	26.2	2.1	100

Table 9.32 Interfere of Emotional problems in social activities

Gender		32) How much of the time have your emotional problems interfered with your social activities?					
		All of the time	Most of the time	Some of the time	A Little of the time	None of the time	Total
Male	N	13	27	64	73	5	182
	%	7.1	14.8	35.2	40.1	2.7	100
Female	N	45	93	182	198	10	528
	%	8.5	17.6	34.5	37.5	1.9	100
Total	N	58	120	246	271	15	710
	%	8.2	16.9	34.6	38.2	2.1	100

32) (Table 9.32) Majority of inmates' (271) emotional problems, interfered a little of the time with their social activities. 2.1% of inmates' emotional problems did not interfere with their social activities.

Table 9.33 True or false statement

True or false statement		Definitely true	Mostly true	Don't know	Mostly false	Definitely false	Total
33)I seem to get sick a little easier than other people	N	78	236	107	228	61	710
	%	11.0	33.2	15.1	32.1	8.6	100
34)I am as healthy as anybody I know	N	84	138	151	276	61	710
	%	11.8	19.4	21.3	38.9	8.6	100
35)I expect my health to get worse	N	116	187	144	259	4	710
	%	16.3	26.3	20.3	36.5	0.6	100
36)My health is excellent	N	16	190	153	218	133	710
	%	2.3	26.8	21.5	30.7	18.7	100

The above table (9.33) explains the perception of inmates about their health status. Based on a true or false statement, the health statuses of inmates have been evaluated.

33) Statement 1- I seem to get sick a little easier than other people. Majority of inmates (236) stated that the statement was mostly true. 8% of inmates stated that the statement was definitely false.

34) Statement 2- I am as healthy as anybody I know. Majority of inmates (276) stated that the statement was mostly false. 8.6% of inmates stated that the statement was definitely false.

35) Statement 3- I expect my health to get worse. Majority of inmates (259) stated that the statement was mostly false. 0.6% of inmates stated that the statement was definitely false.

36) Statement 4- My health is excellent. Majority of inmates (218) stated that the statement was mostly false. 2.3% of inmates stated that the statement was definitely true.

9.3 Results of ANOVA with health status of inmates

Table 9.34 Association of health status with selected socio-demographic factors

(Gender, Age, District, Type of old age homes and Employment status of inmates)

Socio demographic factors	Health status		N=710 Total	P value
	Satisfied	Dissatisfied		
a)Gender				0.006**
Male	119 (65.4%)	63 (34.6%)	182 (100%)	
Female	283 (53.6%)	245 (46.4%)	528 (100%)	
b)Age				0.000**
60-69	102 (80.3%)	25 (19.7%)	127 (100%)	
70-79	193 (62.9%)	114 (37.1%)	307 (100%)	
80-89	98 (40.2%)	146 (59.8%)	244 (100%)	
90-99	9 (28.1%)	23 (71.9%)	32 (100%)	
c)District				0.000**
Chennai	112 (42.7%)	150 (57.3%)	262 (100%)	
Kanchepuram	95 (59.4%)	65 (40.6%)	160 (100%)	
Vellore	60 (44.8%)	74 (55.2%)	134 (100%)	
Thiruvallur	135 (87.7%)	19 (12.3%)	154 (100%)	
d)Type of home				0.025*
Free	196 (51.6%)	184 (48.4%)	380 (100%)	
Paid	174 (63.7%)	99 (36.3%)	273 (100%)	
Free-cum-Paid	32 (56.1%)	25 (43.9%)	57 (100%)	
e) Employment				0.029*
Not employed	131 (55.3%)	106 (44.7%)	237 (100%)	
Self employed	96 (51.1%)	92 (48.9%)	188 (100%)	
Govt employed	27 (64.3%)	15 (35.7%)	42 (100%)	
Cooley	12 (35.3%)	22 (64.7%)	34 (100%)	
Agriculture	12 (57.1%)	9 (42.9%)	21 (100%)	
Private	123 (65.8%)	64 (34.2%)	187 (100%)	
No response	1 (100%)	0 (0.0%)	1 (100%)	

Note : ** denotes significant at 1% level
* denotes significant at 5% level

Table 9.34 shows the association of health status with selected socio-demographic factors of Gender, Age, District, Type of old age homes and Employment status of inmates before joining into old age homes.

a) Gender was significantly [P = 0.006] associated with health status. Majority of male inmates (65.4%) were satisfied with their health status than female inmates (53.6%).

b) The socio-demographic factor of age was highly correlated with the health status of inmates since the P-value was <0.001 level of significance. The age group of 60-69, satisfied with their health status (80.3%) more than all other age groups of inmates.

c) There was a strong correlation between districts with the health status of inmates since the P-value was < 0.001 level of significance. In Chennai, the majority of inmates were dissatisfied (57.3%) with their health status compared with other districts (Kancheepuram 40.6%, Vellore 55.2% and Thiruvallur 12.3%] in Tamilnadu.

d) This table also shows the association of type of old age homes [Free, paid, Free-cum-paid] with the health status of inmates. Type of home was significantly correlated [P < 0.005] with the health status of inmates. Majority of paid home inmates (63.7%) were more satisfied with their health status.

e) Out of 710 inmates, (237) majority of them were not employed. There was a significant difference between past employment status of inmates with their health status since the P-value was < 0.05 level of significance [P = 0.029].

Table 9.35 reveals the result of the association between the health status of inmates with selected socio-demographic factors [Sources of income, Savings, Roommates, Length of stay and Type of food].

f) Sources of income of inmates were significantly associated [P = 0.019] with their health status and the level of significance was <0.05.

g) Out of 710 inmates, 204 were having savings, among them, 63.2% were satisfied with their health status. There was a correlation between savings of inmates with their health status [P = 0.024].

h) The number of roommates in their room was significantly associated with the health status of inmates [P = 0.029]. Majority of inmates (367) were staying with 1 to 3 numbers of roommates. Inmates with 4 to 6 number of roommates were satisfied more (59.8%) with their health status than the other number of roommates.

i) Length of stay of inmates in old age home was strongly associated with the health status of inmates since the P-value was < 0.001 level of significance. Inmates who had stayed more than 5 years in old age homes, were 50.0% dissatisfied with their health status.

j) Type of food, provided in old age home was significantly associated [P < 0.001] with the health status of inmates. Out of 710 inmates, 529 of them were provided by vegetarian food and they were satisfied (60.9%) more with their health status than other inmates.

Table 9.35 Association of health status with selected socio-demographic factors

[Sources of income, Savings, Roommates, Length of stay and Type of food]

Socio demographic factors	Health status		N=710 Total	P value
	Satisfied	Dissatisfied		
f)Sources of income				0.019*
Son	69 (61.6%)	43 (38.4%)	112 (100%)	
Daughter	31 (67.4%)	15 (32.6%)	46 (100%)	
Relatives	53 (61.6%)	33 (38.4%)	86 (100%)	
Pension	40 (57.1%)	30 (42.9%)	70 (100%)	
Property	5 (50.0%)	5 (50.0%)	10 (100%)	
None	204 (52.8%)	182 (47.2%)	386 (100%)	
g)Savings				0.024*
Yes	129 (63.2%)	75 (36.8%)	204 (100%)	
No	273 (54.0%)	233 (46.0%)	506 (100%)	
h)Roommates				0.029*
1 to 3	214 (58.3%)	153 (41.7%)	367 (100%)	
4 to 6	149 (59.8%)	100 (40.2%)	249 (100%)	
Above 6	39 (41.5%)	55 (58.5%)	94 (100%)	
i)Length of stay				0.000**
Less than 1 year	102 (74.5%)	35 (25.5%)	137 (100%)	
1 to 5 years	187 (53.9%)	160 (46.1%)	347 (100%)	
5 to 10 years	93 (50.0%)	93 (50.0%)	186 (100%)	
Above 10 years	20 (50.0%)	20 (50.0%)	40 (100%)	
j)Type of Food				0.000**
Vegetarian	322 (60.9%)	207 (39.1%)	529 (100%)	
Non vegetarian	80 (44.2%)	101 (55.8%)	181 (100%)	

Note : ** denotes significant at 1% level
* denotes significant at 5% level

Table 9.36 describes the association of health status of inmates with selected variables. They are k) Outside visit of inmates, l) Visit of relative to the home, m) Socialization of inmates with others, n) Level of satisfaction with inmates' relationship and o) Family support.

k) Outside visit of inmates was significantly associated with [P = 0.028] health status of inmates. Some old age homes allow their inmates to go outside of the home for shopping, to visit inmates' relatives and for a walk.

l) Visit of relatives to the old age home was also associated with [P = 0.016] health status of inmates. Out of 710 inmates, the majority (616) of inmates' relatives were allowed to visit the home. Among them, 54.9% of them were satisfied with their health status.

m) It also shows the association of socialization of inmates with their health status. There was a significant difference between them and the P-value was < 0.011 [P = 0.005]. Majority of inmates (371) moderately socialized with other members. They share their problems with other inmates and reduce their level of stress.

Table 9.36 Association of health status with selected variables

Variables	Health status		N=710 Total	P value
	Satisfied	Dissatisfied		
k)Outside visit of inmates				0.028*
Allowed	242 (53.5%)	210 (46.5%)	452 (100%)	
Not allowed	160 (62.0%)	98 (38.0%)	258 (100%)	
l)Visit of relatives				0.016*
Allowed	338 (54.9%)	278 (45.1%)	616(100%)	
Not allowed	64 (68.1%)	30 (31.9%)	94 (100%)	
m)Socialize with others				0.005**
Not at all	19 (55.9%)	15 (44.1%)	34 (100%)	
Moderately	232 (62.5%)	139 (37.5%)	371 (100%)	
Completely	151 (49.5%)	154 (50.5%)	305 (100%)	
n)Satisfaction with inmates				0.001**
Satisfied	301 (60.7%)	195 (39.3%)	496 (100%)	
Dissatisfied	101 (47.2%)	113 (52.8%)	214 (100%)	
o)Family support				0.012*
Satisfied	144 (63.4%)	83 (36.6%)	227 (100%)	
Dissatisfied	258 (53.4%)	225 (46.6%)	483 (100%)	

Note : ** denotes significant at 1% level
* denotes significant at 5% level

n) Out of 710 inmates, 496 of them were satisfied with other inmates' relationships. Among them, 60.7% of inmates were satisfied with their health status. There was a strong association between inmates relationship and health status [P = 0.001].

o) Family support was significantly correlated with [P = 0.012] health status of inmates. 227 inmates were satisfied with their family support. Among them 63.4% of inmates satisfied with their health status.

CHAPTER X

Summary and conclusion

10.1 Summary

Old age is characterized by changes in behavioural patterns, which surface with old age. On the heel of modernization due to improved medical technology, health care facilities, increased longevity and reduced birth rate have led to an increase in old age population both globally and nationally. Traditionally in India, the family had been the ultimate provider of services to the elderly. But forces like modernization, industrialization and urbanization have given a challenge to the traditional values of care for aged and the joint family setup which formerly assured honourable status to the aged. These developments have pushed aged to old age homes.

The old age homes have begun to expand rapidly in most metropolitan areas in India. Next to Kerala, Tamilnadu has got the highest number of old age homes. Particularly in Chennai, around 10% of the population consists of senior citizens. But the government does not have any mechanism to monitor or regulate old age homes in the city. Most homes are dirty and personal hygiene is neglected because the inmates are at the mercy of the people who run the homes, (Rajasekaran, 2013).

Development of homes for older persons in India has a long history. The first old age home in India was started in the early eighteenth century. Today, apart from government-run old age homes, there are various non-governmental, private, voluntary and religion-based charitable organizations. Although human longevity has been one of the greatest scientific achievements of this century, yet achievements in quality of life have not kept a similar pace. In a complex scenario of increasing longevity and accompanying disability, accommodation for older people is emerging as a major challenge.

The present study was undertaken with the overall goal of understanding the life satisfaction of the elderly people living in old age homes in Tamilnadu state. The summary of **Chapter I** are followed. The major objectives of the study are;

1) To understand the socio-economic background of the elderly people living in old age homes in Tamilnadu

2) To find out the life satisfaction of inmates in old age homes

3) To identify the living environment of inmates in old age homes

4) To assess the socio-economic support received by the inmates

5) To analyse the health status of inmates and the requirement of medical aids and substances in old age homes.

The present study focused on understanding the existing institutional facilities available for the care of the elderly, men and women, living in old age homes and to obtain a perspective of the elderly on various aspects associated with institutional living. The present study examined the differences in life satisfaction between elderly male and female inmates. The global population aged 60 years or over numbered 962 million in 2017, more than twice as large as in 1980 when there were 382 million older persons worldwide. The number of older persons is expected to double again by 2050 when it is projected to reach nearly 2.1 billion (World population ageing, UN New York, 2017).

The Indian population has increased from 361 million in 1951 to 1.02 billion in 2001 and further to 1.21 billion in 2011. Simultaneously, the number of older people has increased from 19 million to 77 million and further to 93 million (i.e. 7.5 per cent of the total) during the same time span (Registrar General of India, SRS 2011). Tamil Nadu has the highest proportion (2018) of the elderly (10%) next to Kerala, which has 11%. Even among the metros, Chennai has the second-highest proportion of elderly (8%), next only to Kolkata (10%). The statistics indicate a growing need to cater to the special needs of the elderly in Tamil Nadu, given the fact that so many of them have nobody to take care of them at home. In this research, a field study was conducted in the first four highly populated districts (census 2011) in Tamilnadu. They are Chennai, Kancheepuram, Vellore and Thiruvallur.

In this research work, two scales have been used to evaluate the life satisfaction of elderly people living in old age homes. They are;

1) Satisfaction with life scale (SWLS) – 5 Items
2) Oxford happiness questionnaire (OHQ) – 29 items

The living environment is an important component in dealing with the welfare of any specific group. The elderly persons, being less able to be independent, need the care and support of others in several respects. Taking care of the elderly refers mainly to emotional support; on the other hand, the support given to the elderly refers to financial and material support. As age advances, due to deteriorating physiological conditions, the body becomes more prone to illness. The illness of the elderly is multiple and chronic in nature. To evaluate the health status of inmates, the SF-36 questionnaire has been used in this study.

There has been a distinct change in the Indian family system for the past 50 years. Joint families are turning nuclear families. The status of the elderly has also changed in the present family system. In some cases elderly members of relatively rich families or aged persons who have nobody to look after takes shelter in old age homes. Old age homes are of three types. They are (a) Free old age homes (b) Paid old age homes (c) Free-cum-Paid old age homes.

The theoretical framework of the study was explained at the end of the chapter I. In the theoretical part, micro-level theories of ageing and macro-level theories of ageing were analysed. In micro-level, some theories of ageing were explained. They are role theory, quality of life theory, reference group theory, social learning theory, social exchange theory, activity theory, disengagement theory and continuity theory. In macro-level theories of ageing, such as age stratification theory, modernization theory, environmental theory and subculture of the ageing theory are reviewed.

The present study focused on the individual level than environmental level. Thus, the present study attempted to test the theory of quality of life, activity theory and disengagement theory. Quality of life theory explained the basic needs of individuals. Activity theory explained the importance of activeness of elderly people. Disengagement theory explained the decreased interaction between an individual and others in society. The above-mentioned three theories have been applied in this study.

In the **Chapter II**, an attempt has been made to review the studies related to elderly people in old age homes. The researcher has reviewed Indian and foreign studies that have specifically dealt with the 'Elderly people in old age homes'. The reviews have been classified on chronological order. Past two decades (21st century)

reviews have been referred for the study. The review of literature has been collected on the basis of the following themes;

a) Studies related to Socio-economic condition of inmates
b) Studies related to Life satisfaction of inmates
c) Studies related to the Living environment of inmates
d) Studies related to Social support of inmates
e) Studies related to Economic support of inmates and
f) Studies related to the health status of inmates.

The studies reviewed represent research carried out in India and elsewhere. The studies carried out in India represent geographical and socio-economic diversity. These studies were carried out in Mangalore and Mysore in Karnataka, Telangana, Puducherry, Dehradun, Ahmednagar, Odisha, Uttarakhand, Lucknow, Chennai, Uttarakhand, Nagpur, Kerala, Maharashtra, Surat, Jammu, Trivandrum, Jaipur, Gujarat, Hyderabad, Dindigul, Madurai, Chittor, Punjab, Chandigarh and New Delhi. The researchers conducted elsewhere include Iran, Taiwan, Sweden, Lithuania, Netherlands, South Africa, Finland, German, Israel, Korea, Canada, Malaysia, Hong Kong, Northern Italy, Japan, Sweden, America, North Carolina, France, Georgia, Hungary, China, Brazil, Athens, Turkey, Portugal, Britain, Chile Slovakia, Jamaica, and Australia.

The reviewed studies revealed that there was a need to design programs to increase elderly people's interaction with others and establish social networks for them and ultimately these would enhance a sense of the positive quality of life among the elderly. However, many studies have been undertaken to document the condition of the elderly in the country and those living in old age homes. Thus, the review of literature helped the researcher to understand and conceptualize the present study.

In summary, the literature studied on the elderly and old age homes in India reveals two important issues. Firstly, paid old age homes were more privileged than the free old age homes. This was due to the fact that paid institutions were better financed by their inmates and the free institutions were supported by their donors only. Secondly, it revealed that institutions for the elderly seemed to go a long way in improving the quality of life of those elderly people who were admitted to them, and did not have anyone to care for them.

The majority of literature was obtained from different internationally recognized journals such as Indian Journal of Gerontology, Journal of Advanced Nursing, Journal of Gerontological Nursing, The Gerontologist, International Journal of Nursing Studies, Scandinavian Journal of Caring Sciences, Nursing Ethics, Quality of Life Research, and Journal of Gerontology (US). Research papers from the above journals were selected according to international recognition of the journal, citations and topics similar to the study, thus allowing direct comparison of obtained results.

The review of literature also traced how their role and position in society has changed over time. After looking at the different problems facing the elderly in the old age home has presented by different authors, the literature review also presented the loopholes that have been identified in existing social security policies in the developing world. However, many studies have been undertaken to document the condition of the elderly in the country and those living in old age homes. The present research study corroborates with other studies reviewed regarding this particular viewpoint in Indian context specifically in Tamilnadu.

The research methodology was explained in **Chapter III**. In this study, a descriptive research design was adopted. It was described and analysed the life satisfaction of elderly people in old age homes. The study was conducted in Tamilnadu, India. According to the 2011 census, there were 32 districts in Tamilnadu. First, four highly populated districts (census, 2011) of Tamilnadu were selected for research work. They are 1) Chennai, 2) Kanchipuram, 3) Vellore and 4) Thiruvallur.

The field study was conducted in 2018. From each district, five old age homes were studied. Totally the research was conducted in 20 old age homes in Tamilnadu. Out of 20 homes, 9 were free homes, 8 were paid homes and 3 were free-cum-paid homes. Purposive sampling method was adopted. Inclusion and exclusion criteria were used for the selection of participants. Persons aged less than 60 years, mentally retarded and bedridden were excluded from the sample selection. The selected 710 sample inmates include 182 men and 528 women.

Both primary and secondary data were used in this study. A structured interview schedule was used to collect data from the selected sample cases and it was divided into five sections. They are followed;

a) Socio-economic background of the elderly people in old age homes
b) Life satisfaction of inmates
c) The living environment of inmates in old age homes
d) Socio-economic support to inmates
e) Health status of inmates.

The pilot study helped the investigator to equip with an understanding of the overall objective of the study, the research question and objective of each question in the questionnaire and what it is measuring precisely. A sample number of 40 samples were selected so that successive requirements and modifications could be made with the schedule before gathering data from the larger group of respondents. The data were analysed using SPSS Version 20 and the results were recorded as frequencies, means, average and p-values. Tables and figures were used for comprehensive viewing of the results. The ANOVA was used for categorical variables.

Study on the life satisfaction of the institutionalized elderly people is considered as 'sensitive' because it has the potential to bring memories that are emotionally disturbing and painful. The researcher also faced some difficulties while collecting data from the aged. Many of them had a hearing problem and found it difficult to understand the conversations. Many were emotionally upset.

10.2 Summary of major findings

Chapter IV consists of two sections. Section-I explains the profile of 20 old age homes and Section-II highlights the list of homes in Chennai, Kanchipuram, Vellore and Thiruvallur districts.

- Out of 20 homes, 9 were free service homes, 8 were paid homes and only 3 were free-cum-paid homes. 11 old age home's inmates were guided to go to the nearby government hospital. In some homes, (7) visiting doctors were available and they conduct a routine check-up to their inmates to analyse their health condition. Nurses were available only in seven homes.
- Majority of free homes, conduct a monthly medical check-up to their inmates. Only three homes provide ambulance service to their inmates. Intensive care unit was not available in all (20) old age homes. In 11 homes, walkers /wheelchairs

were available and in 12 homes medicines were available to the inmates for fever, cough, pains and etc.

- Majority of homes (14) had got more than one office staff members in their homes. There was no attender in 3 homes and inmates used to do cooking and cleaning for themselves. Out of 20 homes, 18 homes had got television. Majority of homes (14) provided newspaper to their inmates.
- Majority of old age homes (14) provide vegetarian food to their inmates and 6 homes provide vegetarian and non-vegetarian foods. Out of 20 homes, 10 homes provide evening snacks to their inmates. Mineral water was available in 15 homes. 16 could not provide fruits to their inmates. All the homes (20) provide vegetables, grams and milk to their inmates. On the whole, 50% of homes (10) provided a balanced diet to their inmates based on their economic condition.
- Majority of homes (14) had got a common hall, worship place (12) and storeroom (12). Only nine homes had got a dining hall facility. Out of 20 homes, only 8 homes had got attached restroom facility. Only one paid home arranged call button facility in the bedroom of inmates. 12 homes allowed the inmates to go outside, to buy things and visit the relatives with prior permission from the management.
- Majority of old age homes (16) had got medical facilities. 15 homes had garden in their homes. The telephone was available in 12 homes. Out of 20 homes, 8 homes organize social activities for inmates. Social and recreational activities take place a vital role in the quality of life of inmates. It gives psychological support, develops the health status and reduces the negative feeling of inmates.

The socio-economic condition of inmates was analysed in **Chapter V.** According to the census 2011, the first four highly populated districts from Tamilnadu were selected for this research work. From each district, five old age homes were interviewed. In Chennai, a major percentage (36.9%) of 262 inmates was interviewed. From Kancheepuram 160 inmates (22.5%), Thiruvallur 154 inmates (21.7%) and from Vellore 134 inmates (18.9%) were interviewed.

- Out of 20 homes, nearly three fourth of inmates (74.4%) were females (262) and one-fourth of inmates (25.6%) were males (182). It was found that (307) majority of inmates (43.2%) belonged to the age group of 70 to 79 years, 244 inmates (17.9%) were in 80 to 89 years, 127 inmates (17.9%) were in 60 to 69 years and 32 inmates (4.5%) were in 90 to 99 years.

- Majority of (4) free homes were interviewed in Vellore district. 3 paid homes interviewed in Kancheepuram district. All inmates responded to their marital status. Majority of (53.9%) inmates (383) widowed and 35.5% of inmates (252) remained single in life.

- A high proportion of (570) inmates (80.3%) belonged to the Hindu religion. 133 inmates were (18.7%) Christians and 7 were Muslims (1.0%). Out of 710 inmates, 380 inmates were in free old age homes (53.5%), 273 inmates were in paid homes (38.5%) and 57 inmates were in free-cum-paid homes (8.0%). On the whole, more than half of the inmates were staying in the free type of old age homes.

- Majority of inmates belonged to Most Backward Caste community (32.3%). Out of 710 inmates, 252 inmates (35.5%) were unmarried, 275 inmates (38.7%) had not got a son and others (25.8%) had got one or more sons. 22.8% of inmates had got one or more daughters, 38.2% of inmates had got grandchildren and 343 inmates (48.3%) did not have brothers and sisters.

- According to the education of inmates, the highest percentage falls in the middle school level (27.6%) and 2.4% of inmates (17) had done professional courses. Majority of inmates (73.2%) lived in an extended family and 26.8% of inmates lived in a nuclear family.

- Out of 710 inmates, 383 inmates' spouse (53.9%) had died, 35.5% of inmates (252) were single and only 10.6% of inmates' spouses were alive. 134 inmates' children (18.9%) were in other districts of Tamilnadu and 2.5% of inmates' children (18) were in abroad.

- Majority (33.3%) of inmates (237) were not employed and 26.5% of them (188) were self-employed. 34.1% of inmates (242) did not earn any income and highest per cent of (21.3%) inmates (151) earned from Rs.3001 to Rs.5000.

- Out of 710 inmates, 90.1% of inmates (640) were not receiving any pension. Only 9.9 % of inmates (70) were receiving a pension from various schemes; a) 5.9% of inmates (42) were receiving a pension under the Government Employee Pension scheme, b) 0.3% of inmates (2) were from the Family Pension scheme and c) 3.7% of inmates (26) were from the Tamilnadu Government old age pension scheme. 4.2% of inmates (30) received pension above Rs.5000 per month and they were staying in paid homes.

- Inmates spent their retirement money for various reasons. The majority (1.8%) of inmates (15) spent for the treatment, 1.5% of inmates (11) spent on house

construction and 1.3% of inmates (9) reinvested their money. Out of 710 inmates, 54.4% of them (386) did not receive any income and majority (15.8%) of inmates' source of income was their sons. 10 inmates (1.4%) still maintain their own assets. 3 inmates (0.4%) had land assets. 5 inmates (0.7%) had their own house and 2 inmates (0.3%) maintained their business and were receiving income. Out of 710 inmates, 201 inmates (28.3%) had some savings. 509 inmates did not have any savings.

- Nearly half (48.3%) of the inmates (343) were staying in dormitory type of homes and 35.9% of inmates (255) were staying in twin sharing rooms. 51.7% of inmates (367) had stayed with 1-3 roommates and 35.1% of inmates (249) had stayed with 4-6 roommates.

- Inmates joined in an old age home for different reasons. The majority (42.1 %) of inmates (299) had problems with their family members and 38.5% of inmates (273) stated that they did not have anybody to take care of them. The majority (48.9%) of inmates (347) had stayed one year to less than five years and 26.2% of inmates (186) had stayed five years to ten years.

- Out of 710 inmates, 85 inmates (12%) were willing to go back to their home and stay with their family members. 88% of inmates (624) were not willing to stay with their family members. 12.7% of inmates (90) were willing to move from an old age home. But, the majority of inmates (620) had not got the plan to move from their old age home. 54.5% of inmates stated that they did not have any psychological problems. But, 24.4% of inmates had depression.

In **Chapter VI**, two research tools have been used to analysis the life satisfaction of inmates. They are 1) Satisfaction with life scale (SWLS) and 2) Oxford Happiness Questionnaire (OHQ).

Research tool 1: Satisfaction with life scale (SWLS) consists of 5 statements.

Statement -1 'In most ways my life is close to my ideal'. 32.8% of inmates (233) slightly disagree, 3.5% of inmates (25) slightly agree, but no one strongly agrees (0.0%) with the statement -1.

Statement -2 'The conditions of my life are excellent'. The majority (30.0%) of inmates (213) disagrees with the statement and 5.1% of inmates (36) agree with the statement. But no one strongly agrees (0.0%) with the statement -2.

Statement - 3 ‘I am satisfied with my life’. The majority (23.7%) of inmates (168) disagrees with the statement and 18.7% of inmates (133) slightly agree with the statement. But no one strongly agrees (0.0%) with the statement -3.

Statement - 4 ‘So far I have gotten the important things I want in life’. The majority (31.8%) of inmates (226) slightly agree and 25.6% of inmates slightly disagree (8) with the statement -4.

Statement - 5 ‘If I could live my life over, I would change almost nothing’. The majority (41.5%) of inmates (295) agree with this statement. But no one in the home disagree (strongly disagree (0.0%), disagree (0.0%) and slightly disagree (0.0%) with the statement -5.

Research tool 2: Oxford Happiness Questionnaire contains 29 statements.

Statement -1: ‘I don’t feel particularly pleased with the way I am’. This statement was moderately agreed by the majority of (185) inmates (26.1%). but no one in the home strongly disagreed (0.0%) with this statement.

Statement -2: ‘I am intensely interested in other people’. This statement was moderately agreed by (29.6%) majority of (210) inmates and moderately disagreed by 20.3% of inmates (144).

Statement -3: ‘I feel that life is very rewarding’. This statement was slightly disagreed by the majority of (245) inmates (34.5%) and slightly agreed by only 26.6% of inmates (189).

Statement -4: ‘I have very warm feelings towards almost everyone’. This statement was moderately agreed by the majority (34.9%) of inmates (248) and strongly disagreed by 5.1% of inmates (36).

Statement -5: ‘I rarely wake up feeling rested’. This statement was slightly agreed by (36.9%) majority of inmates (262) and slightly disagreed by 22.8% of inmates (162).

Statement -6: ‘I am not particularly optimistic about the future’. This statement was slightly disagreed by (36.3%) majority of inmates (258) and slightly agreed by 29.3% of inmates (208).

Statement -7: ‘I find most things amusing’. This statement was slightly disagreed by (47.6%) majority of inmates (338) and no one strongly agreed (0.0%) with this statement.

Statement -8: ‘I am always committed and involved’. This statement was slightly disagreed by (38.3%) majority of inmates (272) and slightly agreed by 17.3% of inmates (123).

Statement -9: ‘life is good’. This statement was slightly disagreed by (38.7%) majority of inmates (275) and slightly agreed (17.2%) by 122 inmates.

Statement -10: ‘I do not think that the world is a good place’. This statement was slightly disagreed by (40.4%) majority of inmates (287) and no one strongly agreed and strongly disagreed (0.0%) with this statement.

Statement -11: ‘I laugh a lot’. This statement was slightly disagreed by (45.1%) majority of inmates (320) and strongly agreed by only 1.1% of inmates (8).

Statement -12: ‘I am well satisfied with everything in my life’. This statement was moderately disagreed by (40.3%) majority of inmates (286) and no one moderately agreed and strongly agreed (0.0%) with this statement.

Statement -13: ‘I don’t think I look attractive’. This statement was moderately agreed by (43.4%) majority of inmates (308) and no one strongly disagreed (0.0%) with this statement.

Statement -14: ‘There is a gap between what I would like to do and what I have done’. This statement was slightly agreed by (42.4%) majority of inmates (301) and no one strongly disagreed and moderately disagreed (0.0%) with this statement.

Statement -15: ‘I am very happy’. This statement was moderately disagreed by (39.6%) majority of inmates (281) and no one strongly disagreed and strongly agreed (0.0%) with this statement.

Statement -16: ‘I find beauty in some things’. This statement was slightly disagreed by (43.1%) majority of inmates (306) and no one strongly agreed (0.0%) with this statement.

Statement -17: ‘I always have a cheerful effect on others’. This statement was slightly disagreed by (37.9%) majority of inmates (269) and no one strongly agreed (0.0%) with this statement

Statement -18: ‘I can fit in (find time for) everything I want to’. This statement was slightly disagreed by (39.2%) majority of inmates (278) and no one strongly agreed (0.0%) with this statement.

Statement -19: ‘I feel that I am not especially in control of my life’. This statement was moderately agreed by (33.4%) majority of inmates (237) and no one strongly disagreed (0.0%) with this statement.

Statement -20: ‘I feel able to take anything on’. This statement was slightly disagreed by (39.3%) majority of inmates (279) and no one strongly disagreed and strongly agreed (0.0%) with this statement

Statement -21: ‘I feel fully mentally alert’. This statement was slightly disagreed by (34.6%) majority of inmates (246) and no one strongly agreed (0.0%) with this statement.

Statement -22: ‘I often experience joy and elation’. This statement was slightly disagreed by (29.7%) majority of inmates (211) and no one strongly agreed (0.0%) with this statement.

Statement -23: ‘I don’t find it easy to make decisions’. This statement was moderately agreed by (47.0%) majority of inmates (334) and no one strongly disagreed (0.0%) with this statement

Statement -24: ‘I don’t have a particular sense of meaning and purpose in my life’. This statement was slightly disagreed by (33.1%) majority of inmates (235) and no one strongly agreed (0.0%) with this statement.

Statement -25: ‘I feel I have a great deal of energy’. This statement was moderately disagreed by (41.4%) majority of inmates (294) and 10.8% of inmates slightly agreed with this statement.

Statement -26: ‘I usually have a good influence on events’. This statement was slightly disagreed by (40.1%) majority of inmates (285) and no one strongly agreed (0.0%) with this statement.

Statement -27: ‘I don’t have fun with other people’. This statement was slightly agreed by (39.3%) majority of inmates (279) and no one strongly disagreed and moderately disagreed (0.0%) with this statement.

Statement -28: ‘I don’t feel particularly healthy’. This statement was slightly agreed by (30.4%) majority of inmates (216) and slightly disagreed by 24.8% of inmates (176).

Statement -29: ‘I don’t have particularly happy memories of the past’. This statement was moderately disagreed by (39.7%) majority of inmates (282) and no one moderately agreed and strongly agreed (0.0%) with this statement.

- Majority of inmates (408) in old age home (57.5%) moderately had negative feelings and 21.0% of inmates did not have negative feelings. Majority of

inmates (57.5%) moderately satisfied and 33.1% of inmates not at all satisfied with themselves.

- More than half of the inmates (54.4%) stated that their life was moderately meaningful and 41.8% of inmates not at all feel that their life to be meaningful. Nearly half of the inmates (49.6%) stated that their physical environment was completely healthy and 5.8% of inmates stated that their physical environment was not at all healthy.
- Majority of inmates (60.8%) had moderately occupied in a useful activity and 31.3% of inmates not at all occupied in a useful activity. More than half of inmates (52.3%) moderately socialized with others. 43.0% of inmates completely socialized with others and 4.8% of inmates, not at all socialized with others.
- Majority of inmates (69.9%) were satisfied with the relationship of inmates in the home. But 30.1% of inmates were dissatisfied with other inmates' relationship. Majority of inmates (68.0%) were dissatisfied with their family support. Out of them, 65.4% were male inmates and 68.9% were female inmates. 32% of inmates were satisfied with their family support.
- Majority of inmates (91.4%) in the home were satisfied with the safety of their life. Only 8.6% of inmates were dissatisfied with their safety.79.6% of inmates were satisfied with the condition of their living place. But 22% of male inmates and 19.9% of female inmates were dissatisfied with the condition of their living place.
- More than half (56.6%) of the inmates (402) were satisfied with the transport provided by the old age home. But, 43.4% of inmates (308) were dissatisfied with the transport facilities.74.6% of inmates (530) were satisfied with the availability of day to day information. But 25.4% of inmates (180) were dissatisfied with the availability of information.
- Majority of inmates (84.2%) did not have enough money to meet their needs. Only 15.8% of inmates (112) had enough money to meet their needs. Out of them, 24 were male inmates and 88 were female inmates. More than half of inmates (64.2%) had a bank account in their own name. but 35.8% of inmates (254) did not have a bank account.
- 12.8% of inmates were satisfied with the relationship of their children. 23.7% of inmates (109) were dissatisfied and the majority of inmates (59.0%) were not applicable because they were single or did not have children. Out of 710 inmates, 99% of inmates (703) stated that old age home is a good idea, particularly for the helpless,

destitute and marginalized elders. Only 1% of inmates (7) opposed the idea of old age home.

10.2.1 Results of ANOVA with life satisfaction of inmates

❖ The result of ANOVA revealed that there was no significant difference between gender with regard to life satisfaction of inmates [P=0.375] since the P-value was > 0.05 level of significance.

❖ According to the age factor, P-value was > 0.05 with regard to the life satisfaction of inmates in old age homes. Result reveals that all age groups of inmates were dissatisfied with their life satisfaction.

❖ There was a highly significant difference between districts of Tamilnadu with regard to the life satisfaction of inmates and the P-value was <0.001 level.

❖ The result of ANOVA applied between the marital statuses of inmates with regard to the life satisfaction of inmates. It was observed that there was no statistical difference between marital status and life satisfaction of inmates since the P-value was > 0.05 level of significance (P = 0.187).

❖ There was a strongly significant difference between the type of old age homes with regard to the life satisfaction of inmates since the P-value was <0.001 level of significance. Majority of free home inmates satisfied with their life.

❖ One of the socio-demographic factors of Education was not significantly associated (P = 0.733) with life satisfaction of inmates.

❖ There was a highly significant correlation between the types of rooms in old age home with regard to the life satisfaction of inmates since the P-value was <0.001.

❖ It was described that the variable number of roommates was significantly (P = 0.001) associated with life satisfaction of inmates. Majority of inmates (367) were living with 1 to 3 numbers of roommates in this study.

❖ There was no significant difference (P = 0.333) between the length of stay of inmates in old age home with regard to the life satisfaction of inmates since the P-value was > 0.05 Level.

❖ The result revealed that there was a highly significant correlation between living environment and life satisfaction of inmates since the P-value was

<0.011 level. Out of 710 inmates, the majority of (352) inmates stated that their living environment was completely good.

❖ The results revealed that there was a significant difference (P = 0.033) between the visit of relatives in old age home with regard to the life satisfaction of inmates since the P-value was < 0.05 Level of significant.

❖ It is evident from the result that there was a strong correlation between outside visits of inmates with regards to the life satisfaction of inmates since the P-value was 0.001.

❖ The result between the family's visits to the old age home with regard to the life satisfaction of inmates and there was a strong correlation between them since the P-value was <0.001.

❖ In old age homes, the majority of inmates (371) were moderately socialized with others. Result revealed that [P = 0.538] there was no correlation between life satisfaction and socialize with others since the P-value was > 0.05 level of significance.

❖ Out of 710 inmates, the majority of inmates (496) were satisfied with other inmates' relationship in old age home. It was found that there was no significant relation (P=0.119) between life satisfaction and other inmates' relationship.

❖ Result revealed that there was a strong correlation between family supports with regard to the life satisfaction of inmates since the P-value was < 0.001 level of significance.

❖ It was found that there was no significant difference between the safety of inmates with regard to the life satisfaction scores and the P-value was 0.100.

❖ Out of 710 inmates, the majority of inmates (565) were satisfied with their living place (Old age home). Result revealed that there was no correlation between the living place of inmates with life satisfaction scores (P = 0.922).

❖ It was found that there was a correlation between the availability of transport facilities in old age home with regards to their life satisfaction of inmates since the P-value was (0.043) <0.05.

❖ The result of ANOVA applied between the accessibility of information to the inmates and life satisfaction of inmates. There was a highly significant relationship between them and the P-value was 0.006. Many inmates were interested to watch the news on television and the majority of the (74.6%) inmates (530) were satisfied with the availability of information in Old age Home.

❖ It was found that there was a strong significant (P < 0.001) relation between sources of income of inmates and life satisfaction of inmates. Economic condition is one of the most influential factors of life satisfaction. Out of 710 inmates, the majority of inmates (386) did not have any sources of income and out of them, only 37.8% were slightly satisfied with their life.

❖ The results revealed that there was a significant difference (P = 0.002) between the savings of inmates and life satisfaction of inmates. Out of 710 inmates, only 204 inmates had some savings with them. Majority of free home inmates did not have any savings.

❖ It was also found that there was no correlation between assets of inmates and life satisfaction scores since the P-value was > 0.05 level of significance.

❖ Out of 710 inmates, 640 did not receive any pension in old age home. Only 70 inmates were receiving a pension from various Government schemes. There was a correlation between pension received and life satisfaction of inmates since the P-value was (0.011) <0.05 level of significance.

❖ The results revealed that there was a strong correlation between the availability of balanced diet in old age home with regard to the life satisfaction of inmates since the P-value was < 0.001 level of significance.

❖ It was also found that there was no relation between the availability of exercise facilities and life satisfaction scores [P = 0.521]. Some old age homes conduct yoga classes to the inmates inside their homes.

❖ There was a significant difference between life satisfaction of inmates [P = 0.001] with regards to the availability of medical facilities in their home. Majority of old age homes provide moderate medical facilities to the inmates. Particularly free old age homes provide more medical facilities to the inmates than paid homes.

❖ The results revealed that there was no correlation [P = 0.824] between psychological abuse and life satisfaction of inmates.

❖ It was also observed that there was a strongly significant difference between useful activities of inmates with regard to life satisfaction since the P-value was < 0.001 level.

❖ There was a strong correlation between life satisfactions of inmates with regards to their level of happiness since the P-value was < 0.001 level of significance. Out of 710 inmates, the majority of them (327) were not particularly happy (Score 3 – 4). These inmates were 58.1% dissatisfied with their life satisfaction.

The living environment of inmates in old age homes have been analysed in **Chapter VII**.

- Out of 20 homes, 17 homes have established for men and women inmates. Three homes were running only for women inmates. 45% of inmates visited the private hospitals and 55% of inmates visited the Government hospitals. Majority of homes (70%) provide medicines to their inmates for fever, cough, cold, knee pain, headache and etc. In some homes (30%) medicines were not available.
- 50% of homes provide walker/wheelchair to their inmates. In another 50% of homes, walker/ wheelchair were not available. Majority of free homes provide walker / wheelchair to their inmates. 9 homes organize social activities to their inmates. Some homes organize a picnic, pilgrimage and outside visit to their inmates.
- Majority of old age homes (70%) provide vegetarian food to the inmates. Only 30% of old age homes provide vegetarian and non-vegetarian food to their inmates. Out of 20 homes, only 9 homes (45%) provide a balanced diet to their inmates along with vegetables and fruits. Only 4 homes provide fruits to their inmates. All other homes (80%) did not provide fruits to their inmates.
- 70% of homes had a common hall (living area) separately. 30% of homes did not have a common hall and they had only dormitory rooms to live. Majority of homes (60%) had separate worship place to the inmates. But 40% of homes had not got separate worship place and they had only dormitory rooms to live.
- 45% of homes had a dining hall. But 55% of homes had not got the dining hall separately. Few old age homes (20%) had attached restroom facilities to the inmates. 80% of homes had not got attached to restroom facilities. Out of 20 homes, 50% of homes had got a fire extinguisher in their homes. Another 50% of homes did not have a fire extinguisher for emergency purpose.
- Majority of homes (55%) did not allow their inmates to go for an outside visit. Many rules are followed by the management to send the inmates for an outside visit. Only 9 homes (45%) allowed their inmates to go outside for shopping, to meet their relatives/ friends and to do social activities. Out of 20 homes, the majority of homes (65%) had garden inside their campus. Some inmates were very much attached to the garden. Every day they spend some time to take care of the plants. 35% of homes did not have a garden.

10.2.2 Results of ANOVA with living environment of inmates

❖ It was observed that there was no statistical difference between gender and living environment in old age homes since the P-value was 0.547 Level.

❖ Majority of all age group of inmates satisfied with their living environments. It was found that there was no correlation between the age group of inmates (P = 0.558) with their living environment.

❖ Based on the type of old age homes there was a significant difference with regard to the living environment of inmates [P = 0.020].

❖ There was no significant difference [P = 0.110] between living environment with regard to the sources of income of inmates since the P-value was >0.05 level.

❖ It was observed that there was a correlation between [P = 0.035] types of room in old age home with regard to the satisfaction of the living environment.

❖ Since the P-value was very small [P = 0.005] in the association between the level of satisfaction of the living environment and number of roommates was statistically significant.

❖ Results revealed that there was no correlation between length of stay in old age home with regard to satisfaction of living environment since the P-value was larger than 0.05 level of significance [P = 0.396].

❖ There was no significant difference between the type of food (Vegetarian / Non-Vegetarian) with regard to satisfaction of living environment since the P-value was 0.389 level.

❖ Out of 710 inmates, 258 inmates were not allowed by their old age home to go for an outside visit. It was found that there was a significant difference between the outside visit of inmates with regard to satisfaction of living environment since the P-value was < 0.05 level [P = 0.029].

❖ It was found that there was a significant difference between the availability of exercise facilities in old age homes with regard to satisfaction of living environment of inmates since the P-value was < 0.05 level [P = 0.015].

❖ It was observed that there was a significant correlation between medical facilities with regard to satisfaction of living environment since the P-value was < 0.05 level of significance [P = 0.002].

❖ It was observed that there was a significant difference between living environments with regard to inmates' socialization with others since the P-value was < 0.001 level of significance.

❖ Family support with regard to the satisfaction of the living environment was a strong relation between them since the P-value was < 0.001 level of significance. Out of 710 inmates, the majority of inmates (483) were dissatisfied by the lack of family support.

❖ Majority of inmates (649) were satisfied by their safety in old age homes. It was noted that there was a strong correlation between living environments with the safety of inmates since the P-value was < 0.001 level of significance.

❖ It was also observed that there was no significant difference between the transport facility with the living environment [P = 0.253] of inmates.

❖ Out of 710 inmates, 530 inmates were satisfied with the availability of information, There was a significant correlation with access to information in homes with regard to satisfaction of living environment of inmates since the P-value was < 0.05 level of significance [P =0.021].

❖ There was a highly significant difference between useful activities of inmates with regard to the living environment of homes since the P-value was <0.001 level.

In chapter VIII, Socio-economic supports to the inmates have been analysed. It consists of three sections. They are; Section I - Socio-economic support of the family members, Section II - Socio-economic support of the old age home and Section III - Socio-economic support of the Government.

➢ The result shows how often the inmates' family members visited the old age home. 34.5% of inmates (245) stated that they rarely visited and 12.5% of inmates (89) never visited by their family members. Majority of (327) inmates (46.1%) stated that there was no family member to visit them.

➢ Out of 710 inmates, 291 inmates' family members (41.0%) had rarely spoken with the inmates through the phone. 7.3% of inmates' family member speak a few times a year. 46.1% of inmates (327) not applicable because they did not have family members at present.

- Result reveals the level of awareness of inmates about elder abuse. 61.7% of inmates (438) were aware of elder abuse and 272 inmates (38.3%) were unaware of elder abuse. 55.9% of inmates (397) were abused by their family members. 6.6% of inmates (47) were abused by non-relatives and 1.8% of inmates (13) abused by staff members of the old age homes.
- Majority of inmates (80%) were abused by family members in Chennai. The highest percentage of inmates (39%) was abused by non-relatives in Kancheepuram district. Out of 710 inmates, 291 inmates (41.0%) were psychologically abused, 147 inmates (20.7%) were economically abused, 65 inmates (9.2%) were physically abused and 238 inmates (33.5%) were verbally abused.
- The highest percentage of psychological abuse (80%), economic abuse (37%) and physical abuse (18%) had taken place in Chennai. In verbal abuse, Kancheepuram had secured the highest percentage (63%). The result shows the distribution of inmates by their willingness of living arrangements. Majority of inmates (73.2%) wanted to live in old age home. 25.6% of them wanted to live in an extended family.
- Out of 710 inmates, 445 inmates (62.7%) rarely go outside of old age home. 159 inmates (22.4%) had never gone outside of their home. Only 8 inmates (1.1%) were often going outside of the old age home. 182 inmates (25.6%) had got primary caretaker, among them 34.6% were male inmates and 22.5% were female inmates. 11.5% of inmates (82) had got full-time primary caretakers. 74.4% of inmates had not got any primary caretakers.
- 80.7% of inmates (573) stated that their main problem was insufficient money. The highest percentage of inmates in Thiruvallur district was facing the problem of insufficient money. 35.6% of inmates (253) explained their problem of poor medical care. 43.4% of male inmates and 40.2% of female inmates stated that they were being dependent on others. 25.4% of inmates (180) highlighted the problem of their disappointment.
- Result explains the interest of prayer of inmates in old age home. 42.3% of male inmates (77) and 33.7% of female inmates (178) often worshipped their god. 58.3% of inmates regularly prayed. Out of 710 inmates, nearly 80% of inmates (565) were not using the stick. 14.1% of inmates (100) had got the stick through old age home and 6.3% of inmates (45) had purchased themselves. 98.3% of inmates (698) were not

using the crutches. 1.3% of inmates (9) had got crutches through the home and 0.4% of inmates (3) purchased themselves.

- Result highlights the distribution of inmates and the availability of health supportive products. Out of 710 inmates, nearly 90% of inmates (636) were not using the wheelchair. 6.8% of inmates (48) had got wheelchair through the home and 3.7% of inmates (26) had purchased themselves in the paid home. 7.5% of inmates (53) had got walker through the home and 4.8% of inmates (34) had purchased themselves. Out of 710 inmates, no one had used the leg brace, back brace and artificial limbs.

- Out of 710 inmates, nearly 90% of inmates (637) were not using the hearing aid. 4.5% of inmates (32) had got hearing aid through the home and 5.8% of inmates (41) had purchased themselves. 59.2% of inmates (420) were not using the spectacles. 21.0% of inmates (149) had got spectacles through the home and 19.9% of inmates (141) had purchased themselves. 87.6% of inmates (622) were not using the denture. 4.1% of inmates (29) had got denture through the home and 8.3% of inmates (59) had purchased themselves.

- 3.3% of male inmates (6) and 0.9% of female inmates (5) were aware of Indira Gandhi National Old Age Pension Scheme. 3.3% of male inmates (6) and 0.8% of female inmates (4) were aware of the Indira Gandhi National Disability Pension Scheme. 2.2% of male inmates (4) and 0.4% of female inmates (2) were aware of Indira Gandhi National Widow Pension Scheme. 1.6% of male inmates (3) and 0.2% of female inmates (1) were aware of destitute differently-abled Scheme.

- 3.3% of male inmates (6) and 0.6% of female inmates (3) were aware of the Destitute widow's Pension Scheme. 1.1% of male inmates (2) were aware of the Destitute agricultural labourer's Pension Scheme. 2.2% of male inmates (4) were aware of the Deserted wives Pension Scheme. 3.3% of male inmates (6) and 0.4% of female inmates (2) were aware of Pension to unmarried, poor women Scheme.

- 15.4% of male inmates (28) and 14.2% of female inmates (75) were aware of the Chief Minister's health insurance scheme in Tamilnadu. 83.0% of male inmates (151) and 82.6% of female inmates (436) were aware of the Tamilnadu Government old age pension scheme. Majority of inmates (58.2%) expected financial support from the government, 208 inmates (29.3%) expected health care support and no one expected clothing, food and nutritional support from the government.

10.2.3 Results of ANOVA with family support of inmates

❖ The result revealed that there was a significant difference between types of homes with family support of inmates since the P-value was < 0.001 level of significance.

❖ It was observed that age was not significantly associated [P = 0.110] with family support of inmates.

❖ It was found that there was a strong correlation between sources of income with regard to family support of inmates since the value was < 0.001 level of significance.

❖ The result shows the strong relation of the outside visit of inmates with their family support since the value was < 0.001 level of significance [P = 0.000].

Chapter IX elaborates the Health status of inmates in old age homes.

➢ Out of 710 inmates, 59.2% of inmates (420) were satisfied and 40.8% of inmates (290) were dissatisfied to perform their daily living activities. The majority (63.8%) of inmates (453) were satisfied and 36.2% of inmates (257) were dissatisfied with the medical treatment given by old age home. 60.8% of inmates (432) were satisfied and 39.2% of inmates (278) were dissatisfied to get around in old age home.

➢ 56.5% of inmates (401) were satisfied and 43.5% of inmates (309) were dissatisfied with their sleep. 57.6% of inmates (409) were satisfied and 42.4% of inmates (301) were dissatisfied with their capacity for work. 63.2% of inmates (449) were satisfied and 36.8% of inmates (261) were dissatisfied with their memory. Majority (67.2%) of inmates (477) was satisfied and 32.8% of inmates (233) were dissatisfied with access to health services.

➢ 56.6% of inmates (402) were satisfied and 43.4% of inmates (308) were dissatisfied with their health status. 56.5% of inmates (401) were satisfied and 43.5% of inmates (309) were dissatisfied with their energy level for everyday life. 60.4% of male inmates (110) and 65.2% of female inmates (344) were affected by arthritis. Totally, 63.9% of inmates (454) were affected by arthritis.

➢ 49.5% of male inmates (90) and 55.3% of female inmates (292) were affected by cataract. Totally, 53.8% of inmates (382) were affected by cataract. 61.5% of male inmates (112) and 62.1% of female inmates (328) lost their natural teeth. Some inmates were using denture. On the whole, 440 inmates (62%) lost their natural teeth.

- Majority (56.2%) of inmates (399) were affected by high blood pressure. 54.4% of male inmates (99) and 52.5% of female inmates (277) were affected by diabetes. Totally, 53.0% of inmates (376) were affected by diabetes. 28.0% of inmates (199) were affected by asthma. Highest percentages of inmates were affected by arthritis (99%) and cataract (83%) in Thiruvallur district. In Vellore district, 86% of inmates were affected by the loss of natural teeth.

- 1.1% of male inmates (2) and 1.5% of female inmates (8) were affected by the disease cancer. 4 inmates (0.6%) were affected by paralysis, out of them, 3 were male inmates (1.6%) and 1 was female inmate (0.2%). 0.5% of male inmates (1) and 0.4% of female (2) inmates were affected by Alzheimer. No one was (0.0%) affected by dementia. 54 inmates (7.6%) were affected by heart disease, out of them, 10 were male inmates (5.5%) and 44 were female inmate (8.3%).

- 2.7% of male inmates (5) and 1.1% of female (6) inmates were affected by renal disease. 4.4% of male inmates (8) and 7.0% of female inmates (37) were affected by skin disease. 33 inmates (4.6%) were affected by lung disease. Out of them, 4 were male inmates (2.2%) and 29 were female inmate (5.5%). Out of 710 inmates, no one was affected (0.0%) by the liver disease**.**

- 2 male inmates (1.1%) had the habit of smoking. Some paid home inmates continue the habit of smoking in their rooms. No one (0.0%) had the habit of alcohol consumption. 2 male inmates (1.1%) and 3 female inmates (0.6%) had the risky health behaviour of chewing tobacco. In Thiruvallur and Vellore district some inmates continue using tobacco.

- Out of 710 inmates, 624 inmates (87.9%) were using medicines; only 86 inmates (12.1%) were not using medicines. 46.2% of male inmates and 45.6% of female inmates had been using medicines for diabetes. But the majority of inmates (54.2%) were not using the medicine for diabetes. 23.1% of male inmates (42) and 29% of female inmates (153) were using medicines for pain, but the majority of inmates (72.5%) were not using medicines for pain. 39% of male inmates and 33.7% of female inmates were using medicines for other diseases. But 64.9% of inmates were not using the medicine for other diseases.

- Majority of inmates (445) stated that they get most of their medical care from their old age home. Medicines for fever, cough, cold, diarrhea, stomach ache, arthritis, high blood pressure, diabetes, asthma and skin diseases, were provided by the old age home.

 39.6% of male inmates (72) and 36.9% of female inmates (195) were getting most of their medical care from the nearby general hospital. 33.5% of male inmates (61) and 34.3% of female inmates (181) were using self-medication. 32.4% of male inmates (59) and 29.4% of female inmates (155) were getting most of their medical care from a dispensary. 29% of inmates (206) were getting medical care from a private hospital. 20.6% of inmates (146) had problems in the health care center.

 100% of inmates (710) stated that every day they get rice in their food. 99.4% of inmates stated that wheat was rarely available in their food items. 97.7% of inmates (694) stated that jower/ragi were rarely available in their food items. 74.9% of inmates were getting vegetarian food items. 25.1% of inmates were rarely getting the food egg/meat/fish. 91.0% of inmates stated that they get dal every day.

 99.3% of inmates stated that every day the home is providing milk to the inmates. 7.7% of inmates stated that butter /ghee was available every day in their food items. 30.3% of inmates were getting the buttermilk every day. A majority (79.7.5) of inmates (566) stated that the food they get is nutritionally adequate. But 15.6% of inmates (111) stated, their food is nutritionally inadequate. 4.6% of inmates (33) were uncertain about their food. Majority of inmates from free homes were satisfied with their food.

Research tool 3- Health status SF - 36

1. 36.3% of inmates (258) stated that in general their health status was good and 16.6% of inmates' (118) health condition was poor.
2. Compared to one year ago, 5.1% of inmates (36) health status was much better now. Majority (32.5%) of inmates (231) health status was about the same now.
3. 48.3% of inmates' (343) vigorous activities were limited a little and 26.9% of inmates' vigorous activities were not limited at all by their health condition.
4. 44.8% of inmates' (318) moderate activities were limited a little and 32.8% of inmates' moderate activities (233) were not limited by their health condition.
5. 26.3% of inmates' (187) lifting or carrying activities were limited a lot, and 27.9% of inmates' lifting activities (198) were not limited.
6. 45.8% of inmates (325) activity of climbing several stairs was limited a little and 19.9% of inmates' activity of (141) climbing several stairs were not limited at all by their health condition.

7. The activity of climbing some stairs was limited a little to 45.2% inmates and not limited to 36.1% of inmates.

8. The activity of bending was limited a little to 41.1% inmates and not limited to 42.4% of inmates.

9. The activity of walking more than a mile was limited a little to 43.5% inmates and not limited to 25.6% of inmates.

10. The activity of walking several blocks was limited a little to 47.3% inmates and not limited to 26.9% of inmates.

11. The activity of walking one block was limited a little to 35.5% inmates and not limited to 48.0% of inmates.

12. The activity of bathing or dressing themselves were limited a little to 33.4% inmates and not limited to 52.1% of inmates.

13. As a result of their physical health, majority (51.8%) of inmates (368) had problems with work or other activities.

14. Majority (49.3%) of inmates (350) accomplished less than they like,

15. Majority (44.4%) of inmates' (315) work or other activities limited.

16. Majority (45.6%) of inmates (324) had difficulty in performing the work or other activities.

17. As a result of emotional problems, majority (40.4%) of inmates' (287) daily activities had reduced,

18. 45.4% of inmates (322) accomplished less than they like

19. Majority (46.9%) of inmates (333) did not do activities as carefully as usual.

20. 40.1% of inmates' activities (285) slightly interfered and 24.9% of inmates' activities (177) moderately interfered with their social activities because of physical and emotional problems.

21. 45.8% of inmates had very mild body pain and 8.2% of inmates had severe pain during the past four weeks.

22. 34.4% of inmates' pain interfered a little bit with their normal work and 3.5% of inmates' pain extremely interfered with their normal work.

23. Majority (33.5%) of inmates (238) felt full of energy, some of the time and 22.3% of inmates (158) felt full of energy, little of the time.

24. 4.4% of inmates (31) were nervous person all of the time and majority (34.9%) of inmates (248) became nervous some of the time.

25. Inmates have felt that nothing could cheer them up, majority of inmates (271) felt some of the time and 19.3% of inmates felt little of the time.

26. The majority (33.2%) of inmates (236) most of the time felt calm and peaceful and 7.0% of inmates felt calm and peaceful all of the time.

27. Majority of inmates (238) had a lot of energy some of the time and only 2.0% of inmates (14) had a lot of energy all the time.

28. Out of 710 inmates, many inmates felt downhearted and blue and 28.3% of them felt some of the time.

29. Majority of inmates (274) stated that some of the time they felt extremely tired and 8.6% of inmates all the time felt extremely tired.

30. Majority of inmates (212) was happy some of the time and 2.1% of inmates stated that they were not at all happy.

31. 32.3% of inmates felt tired some of the time and 26.2% of inmates felt tired little of the time.

32. Majority (38.2%) of inmates' (271) emotional problems, interfered a little of the time with their social activities. 2.1% of inmates' emotional problems did not interfere with their social activities.

33. Statement 1- I seem to get sick a little easier than other people. Majority of inmates (236) stated that the statement was mostly true. 8% of inmates stated that the statement was definitely false.

34. Statement 2- I am as healthy as anybody I know. Majority of inmates (276) stated that the statement was mostly false. 8.6% of inmates stated that the statement was definitely false.

35. Statement 3- I expect my health to get worse. Majority of inmates (259) stated that the statement was mostly false. 0.6% of inmates stated that the statement was definitely false.

36. Statement 4- My health is excellent. Majority of inmates (218) stated that the statement was mostly false. 2.3% of inmates stated that the statement was definitely true.

10.2.4 Results of ANOVA with health status of inmates

❖ The socio-demographic factor of gender was significantly [P = 0.006] associated with health status. Majority of male inmates (65.4%) were satisfied with their health status than female inmates (53.6%).

❖ The age was highly correlated with the health status of inmates since the P-value was <0.001 level of significance. The age group of 60-69, satisfied with their health status (80.3%) more than all other age groups of inmates.

❖ There was a strong correlation between districts with the health status of inmates since the P-value was < 0.001 level of significance. In Chennai, the majority of inmates were dissatisfied (57.3%) with their health status compared with other districts (Kancheepuram 40.6%, Vellore 55.2% and Thiruvallur 12.3%] in Tamilnadu.

❖ Type of home was significantly correlated [P < 0.005] with the health status of inmates. Majority of paid home inmates (63.7%) were more satisfied with their health status.

❖ There was a significant difference between past employment status of inmates with their health status since the P-value was < 0.05 level of significance [P = 0.029].

❖ Sources of income of inmates were significantly associated [P = 0.019] with their health status and the level of significance was <0.05.

❖ Out of 710 inmates, 204 were having savings, among them, 63.2% were satisfied with their health status. There was a correlation between savings of inmates with their health status [P = 0.024].

❖ The number of roommates in their room was significantly associated with the health status of inmates [P = 0.029], the majority of inmates (367) were staying with 1 to 3 number of roommates.

❖ Length of stay of inmates in old age home was strongly associated with the health status of inmates since the P-value was < 0.001 level of significance.

❖ Type of food, provided in old age home was significantly associated [P < 0.001] with the health status of inmates. Out of 710 inmates, 529 of them were provided by vegetarian food and they were satisfied (60.9%) more with their health status than other inmates.

❖ Outside visit of inmates was significantly associated with [P = 0.028] health status of inmates. Some old age homes allow their inmates to go outside of the home for shopping, to visit inmates' relatives and for a walk.

❖ Visit of relatives to the old age home was also associated with [P = 0.016] health status of inmates.

❖ Majority of inmates (371) moderately socialized with other members. There was a significant difference between health status with socialization of inmates and the P-value was < 0.011 [P = 0.005].

❖ Out of 710 inmates, 496 of them were satisfied with other inmates' relationships. Among them, 60.7% of inmates were satisfied with their health status. There was a strong association between inmates relationship and health status [P = 0.001].

❖ Family support was significantly correlated with [P = 0.012] health status of inmates. 227 inmates were satisfied with their family support. Among them 63.4% of inmates satisfied with their health status.

10.3 Summary of Hypotheses testing

Hypothesis-1 'There would be a significant relationship between life satisfaction and gender of elderly people in old age homes' was rejected [P=0.375] since the P-value was > 0.05 level of significance. Scores in Life satisfaction of male inmates and female inmates were more or less the same. Majority of male inmates (64.2%) and the majority of female inmates (59.7%) secured < 20 scores in life satisfaction (Table 6.13).

Hypothesis-2 'There would be a significant relationship between life satisfaction and type of old age homes' was accepted. The result of ANOVA revealed that there was a strongly significant difference between the type of old age homes with regard to the life satisfaction of inmates since the P-value was <0.001 level of significance. Free old age home inmates had secured high scores in life satisfaction compared with paid home and free-cum-paid home inmates. Majority of free home inmates satisfied with their life (Table 6.14).

Hypothesis-3 'There would be a significant relationship between life satisfaction and accessibility of medical facilities in old age homes' was accepted. There

was a significant difference between life satisfaction of inmates [P = 0.001] with regards to the availability of medical facilities in their home. Majority of old age homes provide moderate medical facilities to the inmates. Particularly free old age homes provide more medical facilities to the inmates than paid homes (Table 6.19).

Hypothesis-4 'There would be a significant relationship between living environment and type of old age homes' was accepted. Based on the type of old age homes there was a significant difference with regard to the living environment of inmates [P = 0.020] since the P-value was <0.05. Particularly, free home inmates were more (83%) satisfied with their living environment than paid home inmates (76%). Majority of inmates in paid homes always find fault with their management and try to move from one old age home to another old age home (Table 7.15).

Hypothesis-5 'There would be a significant relationship between family support and life satisfaction of elderly people' was accepted. Result revealed that there was a strong correlation between family supports with regard to the life satisfaction of inmates since the P-value was < 0.001 level of significance (Table 6.17).

Hypothesis-6 'There would be a significant relationship between the health status of elderly people and gender' was accepted. Gender was significantly [P = 0.006] associated with health status since the P-value was <0.05 level. Majority of male inmates (65.4%) were satisfied with their health status than female (53.6%) inmates (Table 9.34).

Hypothesis-7 'There would be a significant relationship between the health status of elderly people and type of old age homes' was accepted. Type of old age home was significantly correlated [P=0.025] with the health status of inmates since the P-value was <0.05 level. Majority of paid home inmates (63.7%) were more satisfied with their health status (Table 9.34).

10.4 Conclusion

Population ageing is a reflection of three basic demographic processes: fertility rates, mortality rates, and migration rates. The life span represents the theoretical and biological limits to the maximum number of years an individual can live.

At present, the life span for humans is about 100 years, although most die before this age. Life expectancy is an average number of years of life remaining for an individual at a given age. A majority of the aged nations are the most developed nations; the mature countries are found in Africa, Central America, and South Asia.

At present, the elderly comprise a higher percentage of the total population in the more developed nations and regions of the world than in the less developed nations and regions. Those most likely to be voluntarily or involuntarily institutionalized are those who no longer have a sufficient degree of physical or mental competence to continue living independently in the community: those who are very old: those who have no families or whose families are unable or unwilling to care for them; those who live were community-based support services are unavailable or inaccessible and those who are financially or socially disadvantaged. Not surprisingly people with good economic resources and a supportive family tend to enter institutions that provide a higher quality of health care and whose personnel demonstrate greater concern for the residents.

Furthermore once institutionalized, they may become isolated because of language and cultural barriers between themselves, the staff and other residents. They may also receive less attention and care from staff. The number of institutionalized elderly may be increasing for a variety of reasons, first, it has become more culturally acceptable to have elderly parents admitted to an institution, rather than caring for them in the home. At the same time, the increasing size of the elderly population has led to an increase in the number and variety of institutions that are available. These are established with funds from either the private or public sector and receive government subsidies of some type; few institutions for the elderly are still operated by religious or voluntary groups, largely because of increasing expenses.

Most facilities for the elderly are now operated as profit-oriented enterprises. As a result, the nature of the physical and psychological environments and the quality of care can vary greatly from institution to institution. A major factor that determines the quality of care is accountability. If the resident or a relative is paying the total daily cost, and if the resident receives regular visits from non-residents who can check on the quality of care, the resident has a degree of assurance that the care he or

she receives will be reasonably high quality. The status of the resident can also influence the quality of care.

Moreover, in communities with a shortage of institutionalized space, overcrowding often results. This further lowers the quality of care, and the number of viable housing alternatives decreases, except for the most financially and socially advantaged elderly who can pay for better care in private housing. In order to provide housing services and treatment for those who are partially or totally unable to care for themselves, a variety of institutions settings have evolved. Relocation from independent, private living to a form of institutionalization in the later years represents a complete change in lifestyle. While preparing for the first move to an institution can lessen the shock, most people have difficulty in adjusting to the lack of privacy and personal space.

Institutions operated by voluntary organizations or religious groups tend to be more person-oriented and less bureaucratic. When an individual is institutionalized, he or she may experience great stress, especially if the relocation is an involuntary move. The loss of one's home or apartment entails a loss of privacy and personal possessions, disrupts well-established lifestyles and symbolizes rejection, deterioration and the imminence of death. In fact, being institutionalized is often perceived as the penultimate stage in life. Unless the move is voluntary, or the individual is well prepared for the move, the social, emotional and psychological needs of the individual are seldom satisfied in the bureaucratic and depersonalized environment.

The results suggest that while the physical ties of the elderly men and women with their adult children have weakened their psychological and emotional bond with them remains strong. This is reflected by the fact that the majority of the inmates still in the view that children are the main support for parents in old age. Old age home care is the need of the hour. There is also a need for closer supervision in the old age homes. Most of the old age homes are full and they maintain a waiting list for taking the new elderly. In fact, the death of an elderly in an old age home will create a chance for another elderly.

From the results of the study, it is concluded that the majority of the inmates dependent economically, neglected by their relatives, living alone and suffering from

various health problems. It is important to improve the quality of life and make the lives of the inmates more delightful. Inmates need care with a humanitarian approach to ensure a better life. Extra care and support are required for the inmates to lead a peaceful life.

The aim of the study was also to inform about the present state of institutional elderly care in Tamilnadu, to identify key problems in this regard and to suggest improvements. The obtained results could also contribute to the knowledge in the field of gerontological nursing with a particular focus on the Indian context. Dwelling in old age homes in the 21st century should meet some degree of quality of life, to avoid pain and suffering, any kind of maltreatment and neglect and to form pleasant environment, dimensions any human being deserves.

Generally, quality institutional elderly care should meet the degree, where individuals would agree to enter the last stage of their life. Some old age homes offer professional protection for elderly people. Professional protection comprises all types of aid to the elderly person, by means of which functions at home and with his/her family are substituted or fulfilled to the inmates, especially with regard to their dwelling, organized nutrition, security and health protection. Although small in scale, the strength of this study is that it seeks to deepen understandings of the subjective world of older people in relation to their home.

10.5 Recommendations

❖ Cultural activities should be organized to make them happy, active and healthy. Entertainment programs should be arranged with the help of school and college students.

❖ Majority of inmates needed visual, hearing, dental and walking aids. These should be provided by the old age homes. A doctor or a nurse should be available in an old age home. So, they can get their help in an emergency.

❖ Old age homes should have an ambulance facility for transport. In an emergency, they can reach the hospital soon. Counsellors, physiotherapists, and yoga instructors can make differences in the quality of life in old age homes.

❖ Healthy food should be provided to the inmates. A dietician is essential to provide a wholesome, balanced, nutritional diet to the inmates.

❖ As per the dormitory system, a minimum area of 120 square feet is essential for an individual. An individual toilet is essential to reduce inmates' conflicts.

❖ Media should play an important role in bringing out the condition of old age homes and their needs. Apart from all, the younger generation should give respect to the elders and visit the old age homes. Adults should be aware of savings so that they need not depend on their children.

❖ The Government can strengthen the old age pension scheme, old age security scheme and can also give economic support to the free old age homes. They can provide free vehicles for going to the hospital.

❖ The Government may provide free medical treatment and medicines to the inmates. They may also initiate some health-related schemes to the inmates and can provide free electricity and free water supply to the free old age homes.

❖ The non-governmental organization may publish a list of old age homes with all particulars to make it easy for elderly people to select their homes.

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INTERVIEW SCHEDULE

Section I: Socio-Economic background of the elderly people in old age home

1.	Name (Optional)						
2.	Name of the Institution						
3.	Name of the locality						
4.	Name of the district	Chennai	Kancheepuram	Vellore	Thiruvallur		
5.	Type of the home	Free	Paid	Free-cum-paid			
6.	Age						
7.	Sex	Male	Female				
8.	Marital status						
	a)	Single		d)	Separated		
	b)	Married		e)	Divorced		
	c)	Widowed		f)	No response		
9.	Religion						
	a)	Hindu		d)	Jain		
	b)	Muslim		e)	Others		
	c)	Christian		f)	No religion		
10.	Community						
	a)	Forward Caste		d)	Scheduled Caste		
	b)	Backward Caste		e)	Scheduled Tribe		
	c)	Most Backward Caste		f)	No response		
11.	Education						
	a)	Illiterate		d)	Intermediate		
	b)	Primary school		e)	Graduate		
	c)	Middle school		f)	Professional		
	d)	High school		g)	Others		

12.	Number of brothers and sisters (alive)					
	a)	Brother	1	2	3	>3
	b)	Sister	1	2	3	>3
	c)	None				
	d)	Not applicable				
13.	Number of sons (alive)					
	a)	Sons	1	2	3	>3
	b)	None				
	c)	Not applicable				
14.	Number of daughters (alive)					
	a)	Daughters	1	2	3	>3
	b)	None				
	c)	Not applicable				

15.	Number of grand children					
	a)	Grand children	1	2	3	>3
	b)	None				
	c)	Not applicable				

16.	Kind of family you reared in					
	a)	Nuclear Family (Consisting of Parents and Siblings)				
	b)	Extended Family (Parents, Grand Parents, Uncles, Aunts)				
	c)	Orphanage, Foster Home or Institution				
	d)	No response				
17.	Present condition of the spouse					
	a)	Passed away		e)	Another institution	
	b)	With family members		f)	With friends	
	c)	Same institution		g)	Living independently	
	d)	With relatives		h)	Not applicable	
18.	Residence of inmates' children					
	a)	Same locality		d)	In India	
	b)	Same district		e)	Other country	
	c)	In Tamilnadu		f)	Not applicable	
19.	Employment status (before joining into the old age home)					
	a)	Not employed		e)	Cooley	
	b)	House wife		f)	Agriculture	
	c)	Self employed		g)	Others	
	d)	Govt employed		h)	No response	
20.	If employed, earned in past per month					
	a)	<1001		c)	3001 to 5000	
	b)	1001 to 3000		d)	>5000	

21.	Do you get any pension at present?					
	a)	Yes		b)	No	
22.	If yes, amount of pension per month					
	a)	<1001		c)	3001 to 5000	
	b)	1001 to 3000		d)	>5000	
23.	Name of the pension scheme					
24.	If government employed, how was the retirement money spent?					
	a)	Reinvestment		d)	Treatment	
	b)	Education of children		e)	Housing	
	c)	Marriage of children		f)	Others	
25.	Do you receive income from the following sources?					
	a)	Son		d)	Friends	
	b)	Daughter		e)	Property	
	c)	Relatives		f)	None	

26.	What kind of assets do you have now?					
	a)	Land		c)	Business establishment	
	b)	House		d)	None	
27.	Do you have saving?					
	a)	Yes		b)	No	
28.	Type of room where you stay					
	a)	Dormitory		c)	Twin sharing	
	b)	Single occupied		d)	Triple sharing	
29.	How many inmates have stayed in your room?					
	a)	1 to 3		c)	>6	
	b)	4 to 6		d)	None	
30.	Reason to join in old age home					
	a)	No body to take care		c)	Financial problem	
	b)	Family problem		d)	To live independently	
31.	How long are you staying in this home?					
	a)	Less than one year		c)	Five to ten years	
	b)	One to five year		b)	Above ten tears	
32.	Given a chance to stay with your family would you like to go back?					
	a)	Yes		b)	No	
33.	Are you planning to move in near future?					
	a)	Yes		b)	No	
34.	Are you suffering from any of the following problems?					
	a)	Depression		c)	Helplessness	
	b)	loneliness		d)	None	

Section II: Life satisfaction of inmates

Research tool 1 - Satisfaction with life scale (SWLS)

Sl.no	**Statements**	**S.A**	**A**	**SL.A**	**N.A**	**SL.D**	**D**	**S.D**
1	In most ways my life is close to my ideal.							
2	The conditions of my life are excellent							
3	I am satisfied with my life							
4	So far I have gotten the important things I want in life							
5	If I could live my life over, I would change almost nothing							

S.A- Strongly agree, **A**-Agree, **SL.A**-Slightly agree, **N.A**-Neither agree nor disagree, **SL.D**-Slightly disagree, **D**-Disagree, **S.D**-Strongly disagree

Research tool 2 - The Oxford Happiness Questionnaire

Sl.no	Questions		ST.D	MO.D	SL.D	SL.A	MO.A	ST.A
1	I don't feel particularly pleased with the way I am.	R						
2	I am intensely interested in other people.							
3	I feel that life is very rewarding.							
4	I have very warm feelings towards almost everyone.							
5	I rarely wake up feeling rested	R						
6	I am not particularly optimistic about the future.	R						
7	I find most things amusing							
8	I am always committed and involved.							
9	Life is good.							
10	I do not think that the world is a good place.	R						
11	I laugh a lot.							
12	I am well satisfied about everything in my life.							
13	I don't think I look attractive.	R						
14	There is a gap between what I would like to do and what I have done.	R						
15	I am very happy.							
16	I find beauty in some things.							
17	I always have a cheerful effect on others.							
18	I can fit in (find time for) everything I want to.							
19	I feel that I am not especially in control of my life.	R						
20	I feel able to take anything on.							
21	I feel fully mentally alert.							
22	I often experience joy and elation.							
23	I don't find it easy to make decisions.	R						

24	I don't have a particular sense of meaning and purpose in my life.	R						
25	I feel I have a great deal of energy.							
26	I usually have a good influence on events.							
27	I don't have fun with other people.	R						
28	I don't feel particularly healthy.	R						
29	I don't have particularly happy memories of the past	R						

Note: The R (Reverse scored) notation is related to the mathematics at the end of the questions. **ST.D**-Strongly disagree, **MO.D**-Moderately disagree, **SL.D**-Slightly disagree, **SL.A**-Slightly agree, **MO.A**-Moderately agree, **ST.A**-Strongly agree.

Sl.no	Life satisfaction	Not at all	Moder-ately	Compl-etely
1.	How often do you have negative feelings such as blue mood, despair, anxiety, depression?			
2.	How much satisfied are you with yourself?			
3.	To what extent do you feel your life to be meaningful?			
4.	How healthy is your physical environment?			
5.	To what extent do you occupied in a constructive or useful activity? (works, reads, play games)			
6.	How much do you socialize with others?			

Sl.no	Life satisfaction	Satisfied	Dissatisfied
7.	Are you satisfied with the relationship of inmates in the home?		
8.	Are you satisfied with your family support?		
9.	How safe do you feel in your daily life?		
10.	Are you satisfied with the condition of your living place?		

11.	Are you satisfied with the transport provided by the old age home?		
12.	How available to you is the information that you need in your day-to-day life?		

Sl.no	Life satisfaction				Yes	No
13.	Have you enough money to meet your needs?					
14.	Do you have a bank account in your own name?					
15.	Are you satisfied with the relationship of your children?					Mark ✓
	a)	Very satisfied		d)	Very dissatisfied	
	b)	Satisfied		e)	No response	
	c)	Dissatisfied		f)	Not applicable	
16	Do you think that it would be a good idea for aged persons to live in old age homes specially organized for them?					
	a)	Yes		b)	No	

Section III: Living environment of the elderly people in old age home

Profile of the old age home			
1.	Sub-categories in old age homes		
	a)	Free home for men & women	
	b)	Free home for only women	
	c)	Free home for only men	
	d)	Paid home for men and women	
	e)	Paid home for only women	
	f)	Paid home for only men	
	g)	Free-cum-paid home for men and women	
	h)	Free-cum-paid home for only women	
	i)	Free-cum-paid home for only men	
2.	Address		
3.	Phone number		
4.	website		
5.	Management		
6.	Founder of the home		
7.	Year of establishment		
8.	Total area of premise		
9.	Criteria for admission	Above 60 years	No age limit
10.	Bed ridden patients	Allowed	Not allowed

a)	**Nature of accommodation**			
11	Persons accepted/ enrolled/admitted	Men & women	Only women	Only men
12	Total capacity			
13	Total number of floors			
14	Total number of rooms			
15	Present occupancy			
16	Number of males			
17	Number of females			
18	Waiting list			
19	Mentally retarded			
20	Bed ridden			
b)	**Management staffs**			
21	Office staffs			
22	Household worker			
23	Security			
c)	**Entertainment facilities**	Available	Not available	
24	Television			
25	Radio			
26	News paper			
d)	**Food availability**	Available	Not available	
27	Breakfast			
28	Lunch			
29	Evening snacks			
30	Supper			
31	Sources of drinking water			
32	Fruits			
33	Vegetables			
34	Balanced nutritional diet			
35	Type of food	Vegetarian	Non vegetarian	
e)	**Room features**	Available	Not available	
36	Common hall			
37	Dining hall			
38	Worship place			
39	Kitchen			
40	Store room			
41	bath room			
42	Toilets			
f)	**Special features**	Available	Not available	
43	Relatives			
44	Outside visit of inmates			

45	Call button in bed room		
46	Night time nurses		
47	Exercise facilities		
48	Medical facilities		
49	Waste disposal		
g)	**Special features**	Available	Not available
50	Self-cooking in their rooms		
51	Garden		
52	Telephone service		
53	Fire extinguishers		
54	Provide pocket money		

Section IV: Socio-economic support of inmates in old age home

1	How often do your family members visit you in a year?					
	a)	Once a year		d)	Seldom	
	b)	Twice a year		e)	Never	
	c)	More than twice		f)	Not applicable	
2	How often do they talk on the telephone with you?					
	a)	Once a week		d)	Seldom	
	b)	Few times a month		e)	Never	
	c)	Few times a year		f)	Not applicable	

3	Are you aware of elder abuse?	Yes	No
4	Are you abused by family members?		
5	Are you abused by non-relatives?		
6	Are you abused by staff members in old age home?		

7	Which aspect you are abused?					
	a)	Psychological abuse		c)	Physical abuse	
	b)	Economical abuse		d)	Verbal abuse	
8	Which kind of living arrangement do you prefer?					
	a)	Live alone		d)	Live in nuclear family	
	b)	Live with spouse only		e)	Live in extended family	
	c)	Live with children		f)	Live in old age home	
9	How often do you go out of the old age home?					
	a)	Often		d)	Rarely	
	b)	Weekly		e)	Never	
	c)	Monthly		f)	Not applicable	

10	Do you have a primary care giver to help you?					Yes	No
11	If yes, how often he/she is helpful?						
	a)	Full time (day and night)		c)	Only during the day		
	b)	Only during the night		d)	Only when a call		

12	Are you affected by the following problems?					
	a)	Insufficient money		e)	Being dependent	
	b)	Poor housing		f)	Disappointment	
	c)	Poor medical care		g)	Loss of confidant	
	d)	Lack of companionship		h)	Fear of crime	
13	Do you ordinarily pray? (devotion and chanting the name of god)					
	a)	Often		c)	Sometimes	
	b)	Regularly		d)	No	

14	How do you get the following aids?				
	a)	Stick	Through home	I purchase	I don't use
	b)	Crutches			
	c)	Wheel chair			
	d)	Walker			
	e)	Leg brace			
	f)	Back brace			
	g)	Artificial limbs			
	h)	Hearing aid			
	i)	Spectacles			
	j)	Denture			

Social security schemes for the elderly

15	**Do you aware of the following government schemes?**	**Yes**	**No**
a)	Indira Gandhi National Old Age Pension Scheme for aged 60 and above		
b)	Indira Gandhi National Disability Pension Scheme (Till the age of 79 Years)		
c)	Indira Gandhi National Widow Pension Scheme (Age 40 to 79 Years)		
d)	Destitute differently abled Scheme		
e)	Destitute Widows Pension scheme (Not remarried)		
f)	Destitute Agricultural Labourers pension scheme for aged 60 years and above		
g)	Deserted wives Pension Scheme for aged above 30 Years		
h)	Pension to unmarried, Poor women age 50 years and above		
i)	Chief Minister's Health Insurance Scheme. (Annual family income less than <72000)		
j)	Tamilnadu government old age pension scheme for elderly people		

16	What kind of support do you expect from our government?					
	a)	Financial		e)	Food and nutrition	
	b)	Housing		f)	Recreation	
	c)	Health care		g)	Transportation	
	d)	Clothing		h)	No response	

Section V: Health status of inmates in old age home

Health status		Satisfied	Dissatisfied
1)	Are you satisfied with your ability to perform your daily living activities?		
2)	Are you satisfied with medical treatment provided by the home to function in your daily life?		
3)	Are you able to get around?		
4)	Are you satisfied with your sleep?		
5)	How are you satisfied with your capacity for work?		
6)	How would you rate your memory?		
7)	Are you satisfied with access to health services?		
8)	Are you satisfied with your health status?		
9)	Are you satisfied with your energy level for everyday life?		

10)	Are you affected by the following ailments?		Yes	No
	a)	Arthritis		
	b)	High blood pressure		
	c)	Cataract		
	d)	Loss of natural teeth		
	e)	Diabetes		
	f)	Asthma		
11.	Are you affected by any of the following disease?		Yes	No
	a)	Cancer		
	b)	Paralysis		
	c)	Alzheimer		
	d)	Dementia		
	e)	Depression		
12.	Are you affected by any of the following disease?		Yes	No
	a)	Heart disease		
	b)	Renal disease		
	c)	Skin disease		
	d)	Lung disease		
	e)	Liver disease		

13.	Do you have any risky health behaviour?		Yes	No
	a)	Smoking		
	b)	Alcohol consumption		
	c)	Chewing tobacco		
14.	Do you use medicines?		Yes	No
	a)	Medicine for diabetes		
	b)	Medicine for pain in the joints		
	c)	Medicine for other diseases		

15	Where do you get most of your medical care?			
	a)	General hospital	Yes	No
	b)	Private hospital		
	c)	Pharmacist /Dispensary		
	d)	Self-medication		
16	What are your major problems while getting treatment from health care centre?			
	a)	Centre overcrowded	Yes	No
	b)	Long distance		
	c)	Poor supply of medicines		
	d)	Indifferent attitude of staff		
	e)	No problem		

17	What does a typical lunch/dinner consist of?				
	a)	Rice	Every day	Rarely	Never
	b)	Wheat			
	c)	Jower / ragi			
	d)	Eggs, meat, fish			
	e)	vegetables			
	f)	Dal			
	g)	Milk, curd			
	h)	Butter ,ghee			
	i)	Butter milk			

18	Do you think the food that you eat is nutritionally adequate?		
	a)	Adequate	
	b)	Inadequate	
	c)	Uncertain	

Short form – 36 Health Survey 1.0 Questionnaire items

1	In general, would you say your health is:		
	a)	Excellent	
	b)	Very good	
	c)	Good	
	d)	Fair	
	e)	Poor	

2	Compared to one year ago, how would you rate your health in general now?		
	a)	Much better now than one year ago	
	b)	Somewhat better now than one year ago	
	c)	About the same	
	d)	Somewhat worse now than one year ago	
	e)	Much worse now than one year ago	

Does your health now limit you in activities? If so, how much?		Yes, limited a lot	Yes, limited a little	No, not limited at all
3	Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports			
4	Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf			
5	Lifting or carrying groceries			

Does your health now limit you in activities? If so, how much?		Yes, limited a lot	Yes, limited a little	No, not limited at all
6	Climbing several flights of stairs			
7	Climbing one flight of stairs			
8	Bending, kneeling, or stooping			
9	Walking more than a mile			
10	Walking several blocks			
11	Walking one block			
12	Bathing or dressing yourself			

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?			
13	Cut down the amount of time you spent on work or other activities	Yes	No
14	Accomplished less than you would like		
15	Were limited in the kind of work or other activities		
16	Had difficulty performing the work or other activities (for example, it took extra effort)		

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?			
17	Cut down the amount of time you spent on work or other activities	Yes	No
18	Accomplished less than you would like		
19	Didn't do work or other activities as carefully as usual		

20	During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?		
	a)	Not at all	
	b)	Slightly	
	c)	Moderately	
	d)	Quite a bit	
	e)	Extremely	
21	How much bodily pain have you had during the past 4 weeks?		
	a)	None	
	b)	Very mild	
	c)	Mild	
	d)	Moderate	
	e)	Severe	
	f)	Very severe	
22	During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?		
	a)	Not at all	
	b)	A little bit	
	c)	Moderately	
	d)	Quite a bit	
	e)	Extremely	

These questions are about how you feel and how things have been with you during the past 4 weeks							
		All of the time	**Most of the time**	**A good bit of the time**	**Some of the time**	**A little of the time**	**None of the time**
23	Did you feel full of pep?						
24	Have you been a very nervous person?						
25	Have you felt so down in the dumps that nothing could cheer you up?						
26	Have you felt calm and peaceful?						
27	Did you have a lot of energy?						
28	Have you felt downhearted and blue?						
29	Did you feel worn out?						
30	Have you been a happy person?						
31	Did you feel tired?						

32	During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?		
	a)	All of the time	
	b)	Most of the time	
	c)	Some of the time	
	d)	A little of the time	
	e)	None of the time	

How true or false is each of the following statements for you						
		Definitely true	**Mostly true**	**Don't know**	**Mostly false**	**Definitely false**
33	I seem to get sick a little easier than other people					
34	I am as healthy as anybody I know					
35	I expect my health to get worse					
36	My health is excellent					

List of publications during the Post-Doctoral Research period (1)
(2015-2020)

Sl. No	Title of the Article	Name of the Journal	Vol-Iss Page no. & Year	ISSN/ ISBN No.	No. of Auth-ors
1	An Assessment of Quality of Life of Elderly People in Old Age Homes in Chennai City of Tamilnadu	Indian Journal of Gerontology	30-1, 26-47 & 2016	ISSN : 0971-4189	1
2	Usages of Information and Communication Technology (ICT) among Women in Tamilnadu	Research Explorer	5-15, 51-55 & 2017	P-ISSN: 2250-1940 E-ISSN : 2349-1647	1
3	Empowering Women in Digital Knowledge through E-Society	Knowledge Management and E-Society	71-83 & Aug2017	ISBN : 9789381992449	1
4	Impact of Electronic Information Sources on Library System : A Conceptual Analysis	EPRA International Journal of Economic and Business Review	5-11, 32-34 & Nov2017	P-ISSN: 2349-0187 E-ISSN: 2347-9671	1
5	Human Rights in Changing scenario of India : An Overview	SHANLAX International Journal of Economics	6-1, 88-93 & Dec2017	ISSN: 2319-961X	1
6	Differential in Living Standard of Inmates in Old age homes of Chennai (Tamilnadu)	Indian Journal of Gerontology	32-1, 21-35 & 2018	ISSN : 0971-4189	1
7	Air Pollution and Impact Assessment	Research Explorer	6-16, 15-19 & Jan-Mar 2018	P-ISSN: 2250-1940 E-ISSN: 2349-1647	1

List of publications during the Post-Doctoral Research period (2)
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Sl. No	Title of the Article	Name of the Journal	Vol-Issue Page no. & Year	ISSN/ ISBN No.	No. of Auth-ors
8	Teacher Education of Changing Society	International Journal of Research and Analytical Reviews	5-04, 1250-55 & Dec2018	E-ISSN : 2348-1269, P-ISSN : 2349-5138	1
9	Virtual Technologies in improving Library Services : An Overview	Asian Journal of Multidimensional Research	7-12, 101-109 & Dec 2018	ISSN : 2278-4853	1
10	Elder Abuse In Urban Context: With Special reference to Metropolitan Cities in India	Elder Abuse and Social Exclusion	53-61 & Jan2019	ISBN : 9789387587724	1
11	Mounting E-Waste in India : An Emerging Threat to Human Health and Environment of Urban Area	Health, Environment and Society	181-193& Feb2019	ISBN : 9789388316231	1
12	Understanding Cyber Crime and Cyber Laundering: Threat and Solution	EPRA International Journal of Research and Development	5-1, 34-38 & Jan 2020	ISSN: 2455-7838	1
13	Global E-Marketing and Urban Transformation in the 21st century	Studies in Indian Place Names- UGC Care List Journal	40-65, 17-26 & Mar 2020	ISSN: 2394-3114	1
14	Psycho-social factors of juvenile delinquency and intervention strategies	International Journal of Creative Research Thoughts (IJCRT)	936-942, 8-9 & Sep 2020	ISSN : 2320-2882	1
15	Marginalized and institutionalizing elderly women: Issues and concerns	International Journal of Trend in Scientific Research and Development (IJTSRD)	265-268 4-6 & Sep-Oct 2020	E ISSN: 2456-6470	1

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An Assessment of Quality of Life of Elderly People In Old Age Homes in Chennai City of Tamilnadu

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ABSTRACT

The aim of this study was to understand the quality of life of elderly people in old age homes in Chennai city. 350 inmates , 60 years and above (Male = 82, Female 268) were selected by purposive sampling technique from seven old age homes in Chennai city of Tamilnadu. Bed ridden and mentally retarded inmates were excluded from this study. Interview schedule was used to collect data regarding their socio-demographic profile. World Health Organization's Quality Of Life instrument (WHOQOL-Bref) was used to assess the quality of life of inmates in old age homes. Data were analyzed using SPSS software. From the findings, it can be concluded that there was a significant difference between types of old age homes and quality of life of inmates. Factors like Age; Marital status; Condition of the spouse; Education; Money earned in past; Sources of income; Number of roommates and Staying years in old age homes have a significant influence on the quality of life of inmates in old age homes. In Physical capacity domain and Psychological well being domain, male inmates secured high quality of life scores than female inmates. But in Social relationship domain and Environment and living condition domain female inmates secured high quality of life scores than male inmates.

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USAGES OF INFORMATION AND COMMUNICATION TECHNOLOGY (ICT) AMONG WOMEN IN TAMILNADU

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Abstract

ICT forms a platform for information dissemination and it must be utilized properly as it can benefit only those who have an access to it. ICT helps to create public awareness to women issues providing greater access to technology and information and thus closing the gender gap. The effective role of women in sustainability can only be achieved through the equilibrium of the three pillars of the Government, the Private Sector and the Civil Society. The uses of ICT to empower women in remote and scattered areas are proved gradually as to be the best and fastest ways to achieve results.

Keywords *: Information and communication technology, digital empowerment, women entrepreneurs, E-sources, self help groups.*

Introduction

Information and Communication Technology (ICT) is actually a mediator and stands between scientist and public to provide suitable information through several channels. ICT is generally dominated by men, whereas women users are more reluctant to learn the advantage of the ICT application. This ICT illiteracy could hinder women from various work advantages, as well as bring some problems such as data security mistakes, hacked and fraud transactions etc.,(Finarya Legoh, 2011). ICT forms a platform for information dissemination and it must be utilized properly as it can benefit only those who have an access to it. (Isha Sehgal, 2012). ICT helps to create public awareness to women issues providing greater access to technology and information and thus closing the gender gap. It provides an access to information and services for women who are culturally or geographically isolated. It helps women in setting up new businesses and engagement into e-commerce and e-business to generate income and strengthen existing business while creating new employment opportunities. It also offers an opportunity to work from home creating more working conditions for women.

Gurumurthy (2006) indicated that there have been gains for females in the usage of ICT in many sectors, such as e-commerce, e-governance, health and information sharing via the internet. ICT play a major role in helping under privileged section of the society to access information, health care, education, social and economic opportunities and

EMPOWERING WOMEN IN DIGITAL KNOWLEDGE THROUGH E-SOCIETY

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Introduction

Pandit Jawaharlal Nehru once said "To awaken the people, it is women who must be awaken, once she is on the move, the family moves, the village moves and the nation moves" (Pillai, 1995). So there is a strong need for bringing women into main stream of development of India. Today, women share equal status as men. Women have been engaged in communication development since its inception. It was a woman who developed the compiler identified the first computer bug and created the first programs. E-society includes any communication device or application, encompassing radio, television, cellular phones, computer and network hardware and software, satellite system and so on as well as the various services such as video conferencing and distance learning. Some aspects of life, which have a direct influence of e-sources especially on women are a) Women's increased access to job market and improved entrepreneurship, b) increased average household income in villages, c) improved governance d) easy family communication and e) increased social awareness.

Women with minimum educational levels can find opportunities to earn like BPO, Data entry, work from house etc. They can improve their skills through e-learning. Women can share their experiences and learn from other experiences.

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EPRA International Journal of Economic and Business Review SJIF Impact Factor(2017) : 7.144
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Research Paper

IMPACT OF ELECTRONIC INFORMATION SOURCES ON LIBRARY SYSTEM: A CONCEPTUAL ANALYSIS

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ABSTRACT

Electronic information sources are changing library usage patterns. The electronic medium could be the internet, intranets, extranet, satellite TV, CD ROM and etc., E-resources primarily include e-books, e-journals, e-theses, e-newspapers, e-databases and several other materials in electronic form. Open Access Journals available in electronic forms require no space at all and provides fast and easy publishing option. There are many E-databases and all these databases have various features of searching techniques and tools, which are being used by the Librarians to help the users in finding best information in less time. Library 2.0 is a transformation in the way library services are delivered to library users. It provides new tools to make the library space more interactive, collaborative and driven by community needs. A digital library is a live organization that comes to existence through a series of development steps that bring together all necessary constituents. Digital library consortium is a fast means of distance learning to facilitate spread of quality education all over the country and provide large range of e-journals to help the scholars. Libraries play an important role in effectively managing and preserving the open access resources so as to adopt to the information needs of not only today's society but also to the future understanding of the past.

KEY WORDS: *Electronic resources, Digital library, Open access, Journals, Database, Virtual resources, Technologies, Gate way*

INTRODUCTION

Libraries have a long history of collaborative information sharing with the growing role of digital technologies, related to access; interpretation and production of printed texts have been magnified. Libraries are facing with the challenge of delivering electronic reference and information services in a new context in which information explosion, with technological revolution are expected to play a key role. Besides the existing electronic resources, the e-resources which are likely to emerge in the near future may include notes and video of lectures from past courses, home assignments in e-forms like e-term papers, e-project reports, context based e-references, e-indexes, e-subject bibliographies and such other materials. E-resources primarily include e-books, e-articles, e-theses, e-newspapers, e-databases and several other materials in electronic form. Electronic services are changing library usage patterns. Library and information centres act as the hub of information dissemination for the all round development of a nation. Digital libraries are emerging electronic entries that are becoming important in both information resource and information cycles.

E-Learning

It is the delivery of education through various electronic media. The electronic medium could be the internet, intranets, extranet, satellite TV, CD ROM and etc., there are many open source projects dedicated to e-learning. LRN, e Front, ATotar, Caroline, Dokeos, Fle3, Moodle, OLAT are few such examples. Open Access Stakeholders are authors, researchers, Teachers, Students, General Public, Libraries, Universities, Publishers, Funding Agencies, Governments etc., In order to meet the information requirements of the resource persons and the trainees at the institute of library, from time to time gathers information resources from various organizations and institutions at national and international level related to areas of its domain. Some of such organizations are: Ministries and institutes of Government of India: State Administrative Training Institutes, Associations and Academics: RBI, ADB, World Bank, UNDP, UNESCO, OECD, UNPAN, ILO etc.

E-books

More and more traditional book publishers as well as those catering to the professional and business communities are launching their e-book collections. The electronic books market consists of two distinct components, i.e., 1) electronic books consisting of digital materials or contents and 2) electronic book hardware including e-book reading appliance, PCs, Laptop or PDA. Most publishers like Springer, Wiley Inter Science, Taylor and Francis, Cambridge University Press,

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HUMAN RIGHTS IN CHANGING SCENARIO OF INDIA: AN OVERVIEW

Article Particulars

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Abstract

The constitution of India implemented many acts through parliament of India in 21st century and witness to a growing recognition of the place and relevance of human rights. In this article few acts are discussed. They are Whistle Blowers Protection Act, 2011 (provides a mechanism to investigate alleged corruption and misuse of power by public servants), The Protection of Children from Sexual Offences Act, 2012 (gender neutral with respect to pornography, the act criminalizes even watching or collection of pornographic content involving children), National Food Security Act, 2013 (aims to provide subsidized food grains to approximately two thirds of India's 1.2 billion people), Street Vendors (Protection of Livelihood and Regulation of Street Vending) Act, 2014 (regulate street vendors in public areas and protect their rights) and Undisclosed foreign Income and Assets (Imposition of tax) Bill, 2015 (aims to curb black money, and penalty on such income). As far as the concept of human rights are concerned the challenges are to make the people aware of judicial systems, prepare them for political participation, create opportunity for equality, and etc,

Keywords: *Human rights, constitution of India, protection act, disclose, violation, complainant*

Introduction

The constitution of India provides many fundamental rights. The situation of human rights in India is a complex one, as a result of the country's large size and tremendous diversity, its status as a developing country and a sovereign, secular, democratic republic, and its history as a former colonial territory. Although human rights problem do exist in India, the country is generally not regarded as a human rights concern, unlike other countries in south Asia. Based on these considerations, the report freedom in the world 2006 by freedom house gave India a political right of rating of 2, and a civil liberties rating of 3, earning it the designation of free (Tiwari, R.K, 2011).

In India, the 21st century has been witness to a growing recognition of the place and relevance of human rights. Population policies have been contested terrain, with

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Differential in Living Standard of Inmates in Old Age Homes of Chennai (Tamilnadu)

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ABSTRACT

This study focuses on inmates aged 60 years and above in old age homes. Data for this study was collected from three types of old age homes. 129 inmates from free old age homes, 122 inmates from paid old age homes and 99 inmates from free-cum-paid old age homes were selected based on inclusion criteria. The institutionalized elderly were interviewed individually. The inmates were asked to give required information about the organization, nature of accommodation, medical facilities, management staffs, entertainment facilities, food menu, room features and special features. WHOQOL-Bref was also used to compare the quality of life of inmates with various old age homes. On the basis of this study it may be concluded that the paid home inmates secured high quality of life than free home and free-cum-paid home inmates. The findings also revealed that there was a strong relation between types of old age homes and quality of life of inmates.

Key words: Old age home, Paid homes, Free-cum-paid inmates, Associated factors, Quality of life

The Indian family, like most families in oriental culture, is considered to be strong, well knit, resilient and enduring. Old age homes (OAHs) have become a credible alternative accommodation for elders in India due to several factors. Changing family structure, fewer numbers of children in urban, upper and middle class families,

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AIR POLLUTION AND IMPACT ASSESSMENT

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Abstract

Air pollution comes from both natural and manmade sources. There are four major reasons of air pollution are, emissions from vehicles, thermal power plants, industries and refineries. Air quality is worst in big cities like Kolkata, Delhi, Mumbai, Chennai etc., The assessment of air pollution levels for cities in Tamilnadu highlighted that PM10 concentrations in Chennai were higher than the annual average of 60µg/m3 as prescribed under NAAQS. There is no doubt that modern industrial development has been the main instrument in polluting air. Carelessness or poor technology aggravates the amount of pollution produced as do poorly designed processes.

Key words : *Pollutant, pollution emissions, sulphur dioxide, nitrogen dioxide, ozone, respiratory infections.*

Introduction

Air pollution described as contamination of the atmosphere by gaseous, liquid or solid wastes or by-products that can endanger human health and welfare of plants and animals, attack materials, reduce visibility or produce undesirable odours. Pollution is the introduction of contaminants into an environment that causes instability, disorder, harm or discomfort to the ecosystem, i.e., physical systems or living organisms. A pollutant is a waste material that pollutes air, water or soil. Agricultural air pollution comes from contemporary practices which include clear felling and burning of natural vegetation as well as spraying of pesticides and herbicides. Adverse air quality can kill many organisms including humans.

In India, air pollution is believed to cause 527,700 fatalities a year. Older people are majority exposed to diseases induced by air pollution. Those with heart or lung disorders are under additional risk, children and infants are also at serious risk. Air pollution comes from both natural and manmade sources. Man made pollutants from combustion, construction, mining, agriculture and war fare are increasingly significant in the air pollution equation. Motor vehicle emissions are one of the leading causes of air pollution. China, United States and Russia are the world leaders in air pollution emissions. Ozone pollution can cause respiratory disease, cardiovascular disease, throat inflammation, chest pain and congestion.

TEACHER EDUCATION OF CHANGING SOCIETY

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Abstract: *The quality of education is greatly determined by the quality of teachers. The teacher is the most important element in any educational programme. It is the teacher who is mainly responsible for implementation of the educational process at any stage. The major aim of this article is to analyse the regular systems, strategies, role of information and communication technology and inter disciplinary approach in teacher education. This article also highlights the educational issues in teacher education such as lack of professional status, subject knowledge, funds and etc. On the whole the educational issues have led to fall in standards of education. Development of society depends on the quality of education system through qualitative teacher education as well as qualitative and sustainable teaching largely. For effective and worthwhile social change, teacher education should be geared to fulfill.*

Key words: *Teacher Education, Professional status, Education system, Quality education.*

Introduction

Quality of education plays a significant role in nation's development. But the quality of education is greatly determined by the quality of teachers. Teacher education creates an effective environment. The National Knowledge Commission (NKC) has observed that teachers are the single most important element of the school system. Proper education of the teacher enables her to have knowledge of how children grow, develop and learn, how they can be taught efficiently and how their inner potentialities can be brought out and developed. So, teacher education is the base of all education system. The teacher is the most important element in any educational programme. It is the teacher who is mainly responsible for implementation of the educational process at any stage. The key personnel in the institutions who play an important role to bring about this transformation are teachers.

Teachers are responsible persons to shape the behaviour of the pupils. They should develop higher attitude towards the teaching profession, do extremely well in their academic performance and improve lifelong skills to façade in prospect. Moreover, teachers should generate a better teaching learning environment to attain the basic goal of the education (Arunkumar and Jayanta 2014).The teacher be always an essential mediator of knowledge and learning skills, but teacher can no longer fulfill their role satisfactorily in the age of Information and Communication Technology (ICT) without technology aided learning and the access which implies to an increasing body resources and techniques. The National Council for Teacher Education has defined teacher education as a programme of education, research and training of persons to teach from pre-primary to higher education level. Teacher education is a programme that is related to the development of teacher proficiency and competence that would enable and empower the teacher to meet the requirements of the profession and face the challenges therein.

Teaching skills + Pedagogical theory + Professional skills= Teacher education.

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VIRTUAL TECHNOLOGIES IN IMPROVING LIBRARY SERVICES: AN OVERVIEW

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ABSTRACT

World Wide Web has totally changed the meaning of a library. Physical presence has been decreased rapidly with the invention of virtual library. There are many types of e-resources like e-books, e-journals, e-database, e-thesis, e-dissertation and gate ways to deliver the information to the desktops of the users. The major aim of this article is to analyse the role of various systems in improving library services i.e., Open Service Library Management System (OSLMS), Library 2.0, Radio Frequency Identification (RFID), Virtual Reference Service (VRS), Real Simple Syndication (RSS), Knowledge Organization System (KOS), Digital Geo Libraries, Library Automation, Library Cataloguing, Circulation services of library, Acquisitions, Inter-Library Loan (ILL), Library Consortium and Library Portals.. Adoption and adaptation of modern technologies is the need of the hour for any academic institution. The implementation of virtual technologies in library service promises to offer value added services to the existing operations of library and information centers that the electronic age librarians should immediately bank on.

KEYWORDS: *Digital Library, E-Sources, Information Centers, Learning Resources, Virtual Technology.*

7 Elder Abuse In Urban Context: With Special Reference to Metropolitan Cities in India

Dr. M. Suganya Aravazhi

Introduction

Abuse is a single or repeated act, or lock of appropriate action, occurring within a relationship where there is an expectation of trust, which causes harm or distress to an older person (WHO, 2002). Elder abuse is recognized as a global, social and public health problem threatening older people. Older adults constitute the fastest growing segment of the population in many nations. Poverty and disability rates also rise dramatically with age, with disproportionate impact on minority elderly populations and women. Evolving definitions of elder abuse necessarily reflect the cultural contexts in which they emerge, working definitions also describe types of abuse (Physical, Psychological, Financial and Neglect) the victim and perpetrator and the location of abuse (Violence at home or in an institutional setting).

The concept of 'Elder Abuse and Neglect' and response to it were developed in an era when older people were identified as a homogenous group based on chronological and were marginalized by an undertaking of their capacities that was associated with their exclusion from the labor market and with a perception that their roles in society were limited and subject to decline. Most seniors are reluctant to report abuse or neglect of any kind especially if it is perpetrated by a family member. The reasons for this include the fear that they will lose the important relationship they have with that person and the fear of their family's reactions to the abuse being

Mounting E-Waste in India – An Emerging Threat to Human Health and Environment of Urban Area

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ABSTRACT

Electronic waste (e-waste) is one of the fastest growing pollution problems in the world. At present globally more than 52 million metric tons of e-waste is generated or about 7 kg for every person on the earth. India is likely to generate 5.2 million metric tons of e-waste by 2020 from the current level of 2.3 million metric tons and it is the fifth largest e-waste producer in the world. E-waste contains over 1000 different substances and some are hazardous toxic substances such as lead, mercury, cadmium, arsenic, beryllium and etc. This mixture of chemical are harmful to human health and induces adverse effects including nose bleedings, skin diseases, damage to the nervous system, endocrine disruption and etc. The toxic substances in electronic waste seep out into the environment and contaminating land, water and air. In addition, devices are often dismantled in primitive conditions; those who work at these sites suffer frequent bouts of illness. It is noted that about two-thirds of e-waste workers in India are suffering from respiratory ailments like breathing difficulties, irritation, coughing and choking. Only 1.5% of total e-waste is recycled by formal recycling sector in an environmental friendly way. The rapid growth in the amount of e-waste is illegally imported to India for disposal presenting a serious environmental challenge. The Europe, U.S and Japan are the primary origins of e-waste shipments (UNEP). This paper attempts to provide a brief insight into the concept of e-waste, its impact in India and the health and environmental hazards of e-waste. It also highlights the formal and informal recycling economy, e-dump yard, urban mining, e-waste management rules and the immediate strategies to handle this problem.

Keywords: Electronic waste, Toxic substances, Informal recycling, Urban mining, Health hazards

INTRODUCTION

In 21st century, the Information and Communication Technology (ICT) has brought enormous changes in our life.A frequent innovations and technological changes are resulting in shorter life span of ICT equipment and led to an increase in electrical and electronic waste pollution. Electronic waste (e-waste) is the world's most toxic and fastest growing waste stream.E-waste is also known as WEEE [Waste Electrical and Electronic Equipment].The volume of e-waste has also increased drastically in developing and developed nations. At present globally more than 50 million metric tons of e-waste is generated or about 7kg for every person.E-waste is highly complex to handle because of its composition. It contains over 1000 different substances, some are hazardous substances such as lead, mercury, cadmium, arsenic, beryllium and persistent organic pollutants including polychlorinated biphenyls and brominated flame retardants and others are valuable substances like gold, silver, platinum and palladium.

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UNDERSTANDING CYBER CRIME AND CYBER LAUNDERING: THREAT AND SOLUTION

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ABSTRACT

Cybercrime is an illegal action committed in the area of ITC and it is high speed, low cost and high tech offence. This kind of activity usually involves a modification of a conventional crime by using computers. The term 'cyber-laundering' is the practice of money laundering carried out in cyber space through online transactions. This article presents the meaning of cyber laundering dealing with offences concerned with the abuse of computers or other electronic gadgets. Cyber criminals also target at loopholes of mobile devices and the threats are growing faster than it does on personal computer. An effective legal frame work for combating cybercrime is important to develop the correct conceptual apparatus. Cyber criminals often favour those e-commerce portals and payment system where a great number of personal information and credit card data are being stored and processed. On the whole, an effective anti-cybercrime strategy is the need of the hour.

KEY WORDS: *Cybercrime, Money laundering, Information technology, Cyber security, Electronic gadgets, Financial services.*

INTRODUCTION

At present Information Technology and Communication (ITC) has become integral part of every aspect of human life. These have led to the integrated global information environment and every one can access any information in any place around the world without face to face contact. According to internet world states, there are 4.53 billion people (58.8%) are active internet users (June 2019) in the world. The internet user is capable of accessing information on the round the clock basis, can quickly share information with other users. The banking sector is one of the industries, heavily depend on modern technologies and internet. Cybercrime is an illegal action committed in the area of ITC and it is high speed, low cost and high tech offence.

According to UNO expert recommendations, the term of 'cybercrime' covers any crime committed by using computer system or networks, within their framework or against them. Theoretically, it embraces any crime that can be committed in the electronic environment. In other words, crimes committed by using e-computers against information processed and applied in the internet can be referred to cybercrimes.

Cybercrimes are punishable by the Information Technology Act, would be unsuitable as the Indian Penal Code also covers many cybercrimes, such as email spoofing and cyber defamation, sending threatening emails etc. A simple yet study definition of cybercrime would be 'Unlawful acts wherein the computer is either a tool or a target or both'. The computer is a tool for an unlawful act. This kind of activity usually involves a modification of a

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GLOBAL E-MARKETING AND URBAN TRANSFORMATION IN THE 21ST CENTURY

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Abstract

India is witnessing the tremendous growth in e-marketing. It is inexpensive and quick access to digital information and entertainment and in turn, it transforms individuals, businesses, economies and societies. E-marketing is the use of information technology in the processes of creating, communicating and delivering value to customers and its stakeholders.This article focuses on the growing importance of e-marketing, including e-tailing and e-shopping. It also contains a brief description of e-marketing, different methods, benefits,impact of e-marketing and urban transformation. The major strategies of e-marketing include website design and content, search engine optimization, directory submissions, reciprocal linking strategies, online advertising and email marketing. The impact of e-marketing falls across a) Global access, b) Time independence and c) Ubiquity. The prospect of e-shopping is increasing in India because of many factors such as increased internet literacy, perceived usefulness, increased number of working women and entry from the global and local participants. This article also studies about the current scenario of e-shopping in India through e-tailers namely Amazon, Flipkart, Bigbasket and food delivery apps named Zomato and Swiggy. It also sheds light from many different angles on how consumers experience and are influenced by the digital environments in which they are situated as part of their daily lives.

Keywords *E-marketing, E-tailing, E-shopping, Urban transformation, Information technology, Consumers, Internet.*

INTRODUCTION

E-marketing is the use of information technology in the processes of creating, communicating and delivering value to customers and its stakeholders. It is the result of information technology applied to traditional marketing. It increases efficiency and effectiveness in traditional marketing functions and the technology of e-marketing transforms many marketing strategies. This transformation also results in new business models that add customer value and increase company profitability (Schwarzl and Grabowska, 2015).

E-marketing is a time and cost-saving supplement to our overall marketing strategy. Internet marketing strategies include website design and content, search engine optimization, directory

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Psycho-Social Factors of Juvenile Delinquency and Intervention Strategies

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Abstract

The population of young people is growing faster in India and the problem of Juvenile delinquency is more acute in society. A child does not just go badly and suddenly without cause. It is a long term process starting from early childhood. Delinquency is a social and psychological problem. The major psycho-social factors are a) Family background, b) Relations in family, c) Intelligence, d) Personality pattern, e) Urban-Rural setting, f) Perceptual pattern, g) Sex differences, h) Effect of mass media, i) Mode of Socializations, j) Psychopathy, k) Working mothers, l) Socio-Cultural impacts, m) Emotional Stability, n) Interpersonal relations and o) Social networking sites and mobiles. The development and growth of adolescents are pivotal for the development of the society and nation at large. To enhance the well-being of the adolescents, intervention strategies are need of the hour. Some vital intervention strategies are 1) Family oriented Interventions, 2) School-based intervention strategies and 3) through NGOs. At present, adolescence needs guidance from the family and community in all aspects. The school environment should also be supportive, non- threatening and safe. Effective acts, policies and programs are very crucial for the development of the youths.

Keywords

Juvenile delinquency, Adolescence, Psycho-social factors, Interpersonal relations, Socialization, Intervention strategies.

Introduction

Rapid Industrialization has brought Juvenile Delinquency to Indian Life, like all developing countries. The population of young people is growing faster in India and now to educate these growing millions and to give them a purpose in life are some of the challenges. Large urban areas create anonymity which in turn hides antisocial behaviour. Due to urbanization and industrialization, large numbers of people are now migrating from the villages to the towns and the industrialized cities. Bureau of Delinquency Statistics and Research has stated that there is a

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Marginalized and Institutionalized Elderly Women: Issues and Concerns

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ABSTRACT

Ageing women make up a significant proportion of the world's population and their numbers are growing. Poverty is inherently gendered in old age when older women are more likely to be widowed, living alone, with no income, with fewer assets of their own, fully dependent on the family for support and living in old age home. The present study attempts to offer some empirical evidence for understanding and explaining at the marginalization of elderly women. Data for this research work was collected from four old age homes in Chennai city. 60 years and above elderly women were interviewed. Male inmates, bedridden and mentally retarded were excluded from the study. Interview Schedule was used to collect data from female inmates. Low level of awareness and utilization of welfare schemes and programs and low-level social connections and networks, other socio-economic backwardness are the major causes of marginalization of elderly women. Results revealed that majority of female inmates were in the age group of 70 to 79 years (53%), widows (55.7%), illiterates (39.5%), unemployed (65.9%), not having any source of income (50.3%), staying with 6 to 10 roommates (44.3%) and staying above five years (53%) in the old age home. Some major factors influencing marginalization of elderly women are a) Socio-economic backwardness in education and occupation, b) lack of social support among relatives and c) Economic dependency of elderly women. It was analysed that only 0.5% of inmates were satisfied by the availability of money and only 16.2% of inmates were satisfied with the support given by their family members. 49.8% of inmates dissatisfied with health care services provided by the institution and 53.5% of inmates dissatisfied with the condition of their living place due to lack of privacy, narrowed dormitory system, etc.

KEYWORDS: *Marginalization, Elderly women, Institutionalization, Social support, Economic dependency, Old age home*

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INTRODUCTION

Ageing of the population has increasingly become an important issue and concern globally. These concerns grounded in emerging skewed economic futures, social imbalances and individual risks. As per the World Ageing Report, it is estimated that the number of elder persons could increase from 8 per cent in 2015 to 19 per cent in 2050 (United Nations, 2018). The projection also indicates that the number of 60 years and above elderly people in India will increase to 143.20 million in 2021 and 173.2 million in 2026 (Ministry of Social Justice and Empowerment, 2018).

The traditional socio-cultural norms and values of Indian society stressed on showing respect and providing care for the elderly. But with the rising prevalence of nuclear family setups in recent years, the elderly have been exposed to emotional, physical and financial insecurity and with fewer children in the family, the care of older persons in the families get increasingly difficult and facing social isolation. As a result of broad social changes such as migration, modernization, urbanization, late marriage, divorce, higher education and participation of women in employment have a great influence of functions of the family.

Elderly women

Ageing women make up a significant proportion of the world's population and their numbers are growing. The number of women will increase from about 336 million in 2000 to just over 1 billion in 2050. Women outnumber men in older age groups and also in old age homes. Worldwide, there are some 123 women for every 100 men aged 60 and over. The fastest-growing group among ageing women is the oldest-old (aged 80 and above). Worldwide, by age 80 and over, there are 189 women for every 100 men. By age 100 and over, the gap reaches 385 women for every 100 men (World Health Report, 2016).

Many studies revealed that elderly women outnumber elderly men in many old age homes. They are more likely to live in poverty and to be affected by disability and restrictions of mobility. They are more represented among those living in residential care and are at the biggest risk of elderly abuse. Reher and Requena (2018) conducted a study from 61 societies around the world and revealed that the percentages of living alone ranged from as high as 45 to 50 per cent to as low as 5 to 10 per cent. Income insecurity is a significant source of vulnerability among older women. More than four out of five women have either no personal income

Research area photos

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